06474

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

50259 -1770-1

06479

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| GEORGE | BERNARD | ALLEN, SR. | MAY | 11, | 1971 | 8:30 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | SEPT. 7, 1914 | 56 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | DOA MINERS HOSPITAL | LABORER | KELLY TIRE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 33 SOUTH WATER STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | T. | ALLEN | ELIZABETH | | KLOSTERMAN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| NO | N.A. | 216-05-6503 | MRS. GEORGE B. ALLEN, SR., 33 S. WATER FROSTBURG, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Massive Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Artery Heart Disease — 2 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

NONE

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| ✓ | ✓ | YES [ ] NO [X] | ✓ |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | ✓ | ✓ |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | ✓ | ✓ | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from SEPT., 1966, to 5-11, 1971, that (I) (we) last saw the deceased alive on 5-9 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Martin M. Rothstein | | [X] | [ ] | [ ] | 5/13/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| MARTIN M. ROTHSTEIN, M.D. | 48 BROADWAY, FROSTBURG, MD. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 5/14/71 | ROGERS HEIGHTS CEM. | HANCOCK MARYLAND |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARILOU M. SOWERS, Marilou M. Sowers | HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG | MAY 18 1971 | Vernon D. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use in the burial-transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1)
45M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06475

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06480

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First / Middle / Last | MYRTLE (Estella) ANDERSON | | | 2a. DATE KNOWN OF DEATH ☒ / ESTIMATED ☐ Month Day Year | 5-31-71 19 |
| 2b. HOUR | 9a M | | | | |
| 3. SEX | Female | 4. RACE | White | 5. DATE OF BIRTH | July 13, 1892 |
| 6. AGE (In years last birthday) | 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN. | |
| 2c. DATE PRONOUNCED DEAD Month Day Year 19 | MAY 31, 1971 | 2d. HOUR | 9a M | | |
| 7a. BIRTHPLACE (State or foreign country) | W. Va. | 7b. CITIZEN OF WHAT COUNTRY? | USA | 8. MARRIED ☒ / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐ | |
| 9. COUNTY OF DEATH | Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH | Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Memorial Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Housewife |
| 12b. KIND OF BUSINESS OR INDUSTRY | - | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | W.VA. | 13b. COUNTY | Morgan | 13c. CITY OR TOWN | Paw Paw |
| 13d. INSIDE CITY LIMITS? | YES ☒ NO ☐ | 13e. STREET AND NUMBER | Lee Street | | |
| 14. FATHER'S NAME First / Middle / Last | Joel J. Saville | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Rose McCauley | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | 236-20-9285 | 17. INFORMANT ADDRESS | Mrs Violet Foltz, c/o Postmaster Lost City, W. Va. |

## MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — ----

DUE TO, OR AS A CONSEQUENCE OF

(c)

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐ / ASSISTANT MEDICAL EXAMINER ☐ / DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 31, 1971

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | June 3, 1971 | Woodrow Cem. | Paw Paw, (Morgan) W. Va. | |
| 24. FUNERAL DIRECTOR ADDRESS | Johnson Funeral Homes, Berkeley Spgs. W. Va. | 25a. REC'D BY REGISTRAR DATE | JUN 4 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall |

VR A15ME (5) 10M - 1/69

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06476

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06481

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| BERNARD | E. | ARONHALT | 5 19 71 | 7:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 7-24-22 | 48 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, | MEMORIAL HOSPITAL | Clerk | Railroad |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [ ] NO [X] | PO BOX 2114 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | J. | ARONHALT | VIOLA | | LATHRUM |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| Yes | War II | | MEMORIAL HOSPITAL | CUMBERLAND, MD |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Carcinomatosis | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Carcinoma Liver | months |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1948

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH [ ] OR CONTRIBUTING [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-10, 19 71, to 5-19, 19 71, that (I) (we) last saw the deceased alive on 5-10 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DECEASED | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William P. James, MD | | [X] | [ ] | [ ] | 5-19-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. P. JAMES | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 21, 1971 | St. Luke's Cemetery | Cumberland, Md. Allegany |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 24 1971 | Vernon P. Randall |

VR A15(4)
25m-1/70

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06477

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06482

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Howard Middle: A. Last: Atkinson ATKINSON | 2a. DATE OF DEATH Month: 5 Day: 14 Year: 71 | 2b. HOUR M | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 1-13-1899 | 6. AGE (In years last birthday) 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) Penna. | 7b. CITIZEN OF WHAT COUNTRY? USA | B. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH Alleg. Md. |
| 10. CITY OR TOWN OF DEATH Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Sacred Heart D.O.A. Hosp. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Machinist | 12b. KIND OF BUSINESS OR INDUSTRY Navy Yard |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | 13b. COUNTY Allegany | 13c. CITY OR TOWN LaVale | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] 13e. STREET AND NUMBER 1135 Braddock Road |
| 14. FATHER'S NAME First: Edward Middle: Last: Atkinson | | 15. MOTHER'S MAIDEN NAME First: Mary Middle: E. Last: Daly | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. 187-18-9012 | 17. INFORMANT Mable Atkinson-wife Address 1135 Braddock Rd. | |

MEDICAL CERTIFICATION

1B. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) HASCVD ad Acute Myocardial

4100

DUE TO, OR AS A CONSEQUENCE OF (b) Infarction

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) ~~(this hospital)~~ attended the deceased from SEPT 1969 19____, to MAY 71 19____, that (I) (we) last saw the deceased alive on 3-1-71 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) ~~(we)~~ (did) ~~(did not)~~ view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE [signature] DEGREE ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED 5-14-71 | |
| 22d. PHYSICIAN'S NAME (Type) Dr. Matthew Kaufman, M.D. | 22e. ADDRESS Seton Drive, Cumberland, Md. | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 17,1971 | 23c. NAME OF CEMETERY OR CREMATORY Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State) Cumberland Allegany Md. |
| 24. FUNERAL DIRECTOR James F. Scarpelli ADDRESS Cumberland Md. | 25a. REC'D BY REGISTRAR DATE MAY 21 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1
FOR STATE HEALTH DEPT.

06478

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06483

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201. If any entry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Page 2, 3 and 5 may be retained for your files.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If an autopsy has been performed, it should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 4 should be forwarded to the funeral director.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Lillian | Middle: Adelaide | Last: Baldwin | 2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ | Month: May | Day: 4 | Year: 1971 | 2b. HOUR: 12P M | |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: June 26, 1903 | 6. AGE (In years last birthday): 67 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month May Day 4 Year 1971 | | 2d. HOUR: 3 PM | |
| 7a. BIRTHPLACE (State or foreign country): Penna. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Bedford Road | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Clerk | 12b. KIND OF BUSINESS OR INDUSTRY: Insurance Co | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: Bedford Road | | | | | |
| 14. FATHER'S NAME First: William C. | Middle: | Last: Weber | 15. MOTHER'S MAIDEN NAME First: Lavinia | Middle: Rau | Last: | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. J. Homer Lippold | ADDRESS: Friend Cumberland, Md. | | | | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b): Coronary Sclerosis — ------

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port I or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that I took charge of the remoins described above, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county): Rt.9 Cumberland, Md.

22b. DATE SIGNED: May 4, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 6, 1971 | West Side Cemetery | Sunbury, Pa. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 7 1971 | Vernon R. Randall |

VR A15ME (5)
10M - 1/69

1

06479

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06484

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Paula | Lynn | BARNES | 5 | 22 | 71 | 1:45 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) YRS. | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 5-17-71 | | 5 | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | INFANT | -- |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FLINTSTONE | YES [ ] NO [X] | Greene Ridge Rd. STAR ROUTE, BOX 84 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PAUL | HERMAN | BARNES | ANONA | ALENE | GOLDEN |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| -- | 800-01-0531 | Paul H. Barnes Box 84 Star Route Greene Ridge Rd. MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 days

DUE TO, OR AS A CONSEQUENCE OF (b) CROSS BRAIN DAMAGE — 5 days

DUE TO, OR AS A CONSEQUENCE OF (c) HYPOXIA during Delivery ??? — 5 days

7769 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

POST MATURITY

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [✓] NO [ ] | yes |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| [ ] / [ ] | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-17 19 71, to 5-22, 19 71, that (I) (we) last saw the deceased alive on 5-22 19 71, and that in (my) (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | MD | [✓] | [ ] | [ ] | 5-24-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. FLEMING, CMG+ | CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 5/24/71 | GLENDALE CEMETERY | FLINTSTONE, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. WAYNE GEORGE CUMBERLAND, MD. | MAY 28 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06480 06485

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIRGIL | MARION | BARNES | 05 25 71 | 2:40 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 06 26 99 | 71 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | MARRIED XX | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED-H.D. DAVIS LUMBER CO. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | RT. #1, CUMB. | YES / NO X | RT. #1, CUMBERLAND, MD. Bowman's Addition |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| AMBROSE | | BARNES | (SHAFFER) AERIE | | BARNES |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 217-10-6714 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

**MEDICAL CERTIFICATION**

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Bl Lobe Pneumo. | 6 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Mi Infarct. | 6 days |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Multiple myeloma | Unknown |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0799

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO X | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 1B.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-19, 1971, to 5-25, 1971, that (I) (we) last saw the deceased alive on 5-25 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYS. X / MED. DIRECTOR / STAFF PHYS. | 5/26/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| B. SCHINDLER, M.D. | 43 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 26, 1971 | PINE GROVE CEMETERY | RED CLEARVILLE, BEDFORD PA. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|---|
| SILCOX-MERRITT FUNERAL SERVICE, | DECATUR ST., | CUMB. MD. | JUN 1 1971 | Vernon A. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06481

06486

1. DECEASED-NAME (Type or print): First LILLIAN Middle M. Last BRILL
2a. DATE OF DEATH: Month MAY Doy 5 Year 1971
2b. HOUR: 2:30P M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 2 14 89
6. AGE (In years last birthday): 82 YRS.
IF UNDER 1 YEAR: MONTHS DAYS
IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): ~~XXXX~~ Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: QUEEN CITY TOWERS
14. FATHER'S NAME: First Thomas Middle Last HARDING
15. MOTHER'S MAIDEN NAME: First Emma Middle Lost Gavigan
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: ~~XXXXXXXX~~ None
17. INFORMANT: MEMORIAL HOSPITAL, Address CUMBERLAND, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o) [illegible]
DUE TO, OR AS A CONSEQUENCE OF (b) [illegible]
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 4123
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 [illegible]

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this haspital) attended the deceosed from [illegible], 19 71, to [illegible], 19 71, that (I) (we) last saw the deceased alive an [illegible] 19 71 and that in (my) (aur) apinian death occurred on the date ond haur and from the causes stated above, (I) (we) (did) (did nat) view the body after deoth.

22b. SIGNATURE [illegible] M D DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED 5
22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER PA
22e. ADDRESS CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE 5/8/71
23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park
23d. LOCATION (City or Town) (County) (Stote) Cumberland Allegany Md.
24. FUNERAL DIRECTOR ADDRESS Byron Kight Cumberland, Md.
25a. RECD BY REGISTRAR DATE MAY 11 1971
25b. REGISTRAR'S SIGNATURE Vernon O. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the haspital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A16-(4) 25m-1/70

1

06482

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06487

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HELEN | MARGARET | BRUNER | 05 09 71 | 9:50 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | APRIL 15, 1913 | 58 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | UNITED STATES | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNSYLVANIA | | HYNDMAN | YES [X] NO [ ] | |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| HARVEY | | STUBY | NORA | | PIESEL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 187 01 3616 | HOSPITAL RECORD, 900 SETON DRIVE, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Adrenal Insufficiency

DUE TO, OR AS A CONSEQUENCE OF (b) Steroid therapy

DUE TO, OR AS A CONSEQUENCE OF (c) Treat. for severe Rheumatoid Arthritis

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes mellitus.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Yeor 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this haspital) attended the deceased from _____, 19____, ta _____, 19____, that (I) (we) last saw the deceased alive an _____ 19____, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Clarence J. Vincent M.D. | M.D. | [X] | [ ] | [ ] | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| CLARENCE J. VINCENT, M.D. | 924 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 11, 1971 | Hyndman Cemetery | Hyndman, Bedford C., Pa. 15545 |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| ZIEGLER'S FUNERAL HOME, HYNDMAN, PA. 15545 | MAY 14 1971 | Vernon G. Randall |

VR A15 (4)
25m-1/70

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06483 — 06488

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: HENRY | Middle: WALTER | Last: BUCY | 2a. DATE OF DEATH: Month 05 | Day 10 | Year 71 | 2b. HOUR: 7.00 A.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 06 30 82 | 6. AGE (In years last birthday): 88 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): W. VA. | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): WESTERN MARYLAND RAILROAD | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 217 GLENN ST. | | | |
| 14. FATHER'S NAME First: WALTER | Middle: A. | Last: BUCY | 15. MOTHER'S MAIDEN NAME First: (KELLEY) JANE | Middle: | Last: BUC Y | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 705 10 8482 | 17. INFORMANT: PATIENT'S HOSPITAL RECORD | Address: 900 SETON DRIVE CUMBERLAND, MD. | | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): myocardial disease — 2 years

DUE TO, OR AS A CONSEQUENCE OF

(b): coronary ulcers — 2 years

DUE TO, OR AS A CONSEQUENCE OF

(c): arteriosclerosis — 5 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) — UNDERLYING [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 4-7, 19 71, to 5-10, 19 71, that (I) (we) last saw the deceased alive on 5-9, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L. Brings | MD | [X] | [ ] | [ ] | 5-10-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. BRINGS, M.D. | 57 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 5/13/1971 | Sunset Memorial Park | Nr. Cumberland | Alleg | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| HAFER FUNERAL HOME, | 230 BALTO., AVE., CUMB., MD. | MAY 13 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (5-(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06484 06489

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| THOMAS | LEE | CAIN | MAY 14 1971 | M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | MARCH 14, 1925 | 46 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | MINERS HOSPITAL | SPINNING DEPT. | CELANESE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES ☐ NO ☒ | ROUTE 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | H.. | CAIN | ANNIE | | LEAKE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| YES | WW 2 | 218-16-4525 | MRS. HELEN HUGHES, MIDLAND, MD. 21542 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 26 hrs.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver — years
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Feb., 1971, to May 14, 1971, that (I) (we) last saw the deceased alive on May 13 1971, and that in (my) (our) apinian death accurred on the date and hour ond from the causes stated abave. (I) (we) (did) (did not) view the bady after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Leslie R. Miles M.D. | | ☒ | ☐ | ☐ | 5-15-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| LESLIE R. MILES, M. D. | LONACONING, MD. 21539 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 17, 1971 | ST. MICHAEL'S CEMETERY | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | MAY 19 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1

FOR STATE HEALTH DEPT.

06485

MARYLAND STATE DEPARTMENT OF HEALTH

Item#1,6,Film G436 5/19/71 kam

06490

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) | First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|---|
| | Frederick | Zihlman | CALLIS | X | May | 7, | 71 19 | 1 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | 11-24-17 | 72 53 YRS. | | | | | May | 7, | 1971 19 | 2 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | USA | MARRIED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Luke | W.Va.Pulp Mill | Millwright | Paper |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md | Allegany | Westernport | YES X NO | 116 Greene St. |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| Joseph W. Callis | Florence Wiland |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| no | 217-05-1108 | Mrs. Floretta Callis--Wife |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis,left — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21a. EXTERNAL CAUSE WAS PRIMARY / CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes X, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐

ASSISTANT MEDICAL EXAMINER ☐

DEPUTY MEDICAL EXAMINER X

22b. DATE SIGNED: May 7, 1971

ADDRESS(Street, city, town, or county)

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 10,1971 | Philos | Westernport,All.Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| W. Harold ~~XXX~~ Fredlock, Piedmont, W.Va. | MAY 13 1971 | Vernon O. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DA3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper, page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

06486

**MARYLAND STATE DEPARTMENT OF HEALTH**
**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**

# CERTIFICATE OF DEATH

06491

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HELEN | F. | CLAY | MAY 9, 1971 | 7:30 A.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 5-1-04 | 66 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | RETIRED SCHOOL TEACHER | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNA | | ROCKWOOD | YES [ ] NO [ ] | 750 BROADWAY |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | F | SEMBOWER | GRACE | | BOYER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| | 170-36-2919 | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Intractable heartfailure | 2 months |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Aortic stenosis. | yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Coronary artery disease. | yrs. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary embolism.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / (If either, notify medical examiner) — UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I **certify** that (I) (this hospitol) attended the deceased from 3/15, 19 71, to 5/9, 19 71, that (I) (we) last saw the deceased alive on 5/8 19 71, and that in (my) (our) opinion death occured on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| P.B. Halmos | MD | [X] | [ ] | [ ] | 5/9/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| P. B. HALMOS, M.D. | MEMORIAL HOSPITAL, CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | May 12 1971 | Rockwood I.O.O.F. Cemetery | Rockwood Somerset Pa. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hoyt-Lowry Funeral Home Gary Lynn Beachy | 60 W. Main St. Frostburg Md. 21532 | MAY 20 1971 | Vernon G. Randall |

1
FOR STATE HEALTH DEPT.

06487

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06492

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| DONALD | E. | CONRAD | ☒ | MAY | 19 | 1971 | 3p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month / Day / Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | OCT. 10, 1935 | 35 YRS. | | | MAY 19 1971 | 8p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| MT. SAVAGE | | TRUCK DRIVER | LUMBER |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | MT. SAVAGE | YES ☐ NO ☐ | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| GEORGE | L. | CONRAD | DELLA | | KNIERIEM |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|---|
| YES | KOREAN | 215-38-9405 | MRS. ALICE CONRAD, MT. SAVAGE, MD. 21545 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Gunshot of Head | 1-2 Hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | (Self Inflicted) | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

955X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☒, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

22b. DATE SIGNED MAY 19, 1971

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M. D.

ADDRESS(Street, city, town, or county) CUMBERLAND, RD 9

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 22, 1971 | METHODIST CEMETERY | MT. SAVAGE, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | JUN 2 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

1

06488

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06493

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Lost | |
| Delcia | M. | Cosner | |
| 2a. DATE OF DEATH Month Day Year | | 2b. HOUR | |
| 5 - 26 - 71 | | 6 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years, if under 1 year lost birthday) / IF UNDER 1 YEAR: MONTHS, DAYS / IF UNDER 24 HRS.: HOURS, MIN |
| Female | White | 4-12-92 | 77 YRS. |
| 7a. BIRTHPLACE (State or foreign country) W.VA. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐ | 9. COUNTY OF DEATH Allegany Md. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cumberland | Cumb. Nursing Center | HOUSE WIFE | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ / 13e. STREET AND NUMBER |
| Maryland | Allegany | Cumberland | Rt. 5 Winchester Rd. |
| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First / Middle / Lost |
| Edward | | McNemar | Lucy Ann Roberts |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
| No | 236-36-2042 | Miss Bernice Cosner | Rt.5 Winchester Rd. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cerebral Vascular Accident | 4 days |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Arteriosclerotic CVD - advanced | 15 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

4124

Conditions, if ony, which gove rise to immediate couse (a), stoling the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While ☐ Not while ☐ at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceased from 05/06, 1970, to 05/26, 1971, that (I) (we) last saw the deceased alive on 5-26 1971, and thot in (my) (our) opinian deoth occurred on the date and haur and from the causes stated above, (I) (we) (did) (did not) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Martin M. Rothstein | | ☑ | ☐ | ☐ | 5/27/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| MARTIN M. ROTHSTEIN M.D. | 48 BROADWAY - FROSTBURG - MD. 21532 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/29/71 | Nethken Hill Cemetery | Elk Garden Mineral W.Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Silcox-Merritt Fun. Hm. | 404 Decatur St. Cumberland, Md. | JUN 1 1971 | Vernon O. Randall |

VR A15 (4)
45M - 1/69

1

06489

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06494

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| DAVIS | EDITH | PEARL | 05 | 22 | 71 | 8:35 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | JULY 6, 1891 | 79 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | UNITED STATES | WIDOWED XX | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| WEST VIRGINIA | GRANT | SCHERR | YES / NO | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| DAVID | | MC DONALD | ELIZABETH | | FEASTER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 234 62 3629 | HOSPITAL RECORD, | SACRED HEART HOSPITAL 900 SETON DR., CUMB., MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7 WKS

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerotic Heart disease — 10 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-12-71, 19____, to 5-22, 19 71, that (I) (we) last saw the deceased alive on ____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE: ATTENDING PHYS. / MED. DIRECTOR / STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|
| Wayne Spiggle | ATTENDING PHYS. ☑ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| WAYNE SPIGGLE, M.D. | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Buried. | May.25,1971 | Maysville Cemetery | Maysville W.Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Byron Right FUNERAL HOME | Cumberland, Md. | MAY 28 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06490

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06495

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the local Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost |
|---|---|---|
| Margaret | M. | Davis |

2a. DATE OF DEATH: KNOWN ☐ ESTIMATED ☐ Month May Day 19 Year 71 — 2b. HOUR 8:05 M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN |
|---|---|---|---|---|---|---|---|
| Female | White | Nov. 11, 1894 | 76 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month May Day 19 Year 1971 — 2d. HOUR 8:05 M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.Va. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 304 Arch St. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| William | Giles | | Nora | McElwee | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | 214-07-0234 | Mr. Ethelbert Davis, Cumberland Md. Husband |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Gastric Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 4 days

535X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Gastritis — 2 weeks

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

ADDRESS (Street, city, town, or county) Cumberland, Md.

22b. DATE SIGNED May 19, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 22, 1971 | Hillcrest Burial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 25 1971 | Vernon R. Randall |

VR A15ME (5)
10M - 1/69

1

06491

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06496

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EDITH | Middle: SUE | Last: DAWSON | 2a. DATE OF DEATH Month: 05 Day: 10 Year: 71 | 2b. HOUR: P 11:40 |
| 3. SEX: FEMALE | 4. RACE: CAUC. | 5. DATE OF BIRTH: 10-25-14 | 6. AGE (In years last birthday): 56 XX YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Cashier | 12b. KIND OF BUSINESS OR INDUSTRY: Light & Power Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 787 FAYETTE STREET | |
| 14. FATHER'S NAME First: EDGAR | Middle: J. | Last: DAWSON | 15. MOTHER'S MAIDEN NAME First: S. | Middle: EDITH | Last: Milburn |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214 05 7821 | 17. INFORMANT: HOSPITAL RECORD | Address: SACRED HEART HOSPITAL, 900 SETON DR., CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION

DUE TO, OR AS A CONSEQUENCE OF (b): ASCVD

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

21a. ACCIDENT WAS UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐ (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (~~this hospital~~) attended the deceased from 5-19, 1970, to 5-11, 1971, that (I) (we) last saw the deceased alive on APRIL 1971, and that in (my) (our) opinion death occurred on the date and hour and from the couses stoted above, (I) (~~we~~) (did) (~~did not~~) view the body after deoth.

22b. SIGNATURE: Dr Matthew L Kaufman MD DEGREE ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ 22c. DATE SIGNED: 5-11-71

22d. PHYSICIAN'S NAME (Type): MATTHEW L. KAUFMAN, M.D. 22e. ADDRESS: 924 SEXTON DRIVE, CUMBERLAND, MD. 21502

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/13/71 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Mausoleum | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany Md. | |
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: GEORGE'S FUNERAL HOME, 202 GREENE ST., CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: MAY 17 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A1 (M) 25m-1/70

10-25-14

ALLEGANY COUNTY

SACRED HEART

CLEENAY

DAWSON

EDITH

727 FAYETTE STREET

SACRED HEART HOSPITAL

214 05 7221 HOSPITAL RECORD, 900 SEVENTH ST., CUMBERLAND,

MATTHEW L. KAUFMAN, M.D. 924 SEXTON DRIVE, CUMBERLAND, MD. 21502

GEORGE'S FUNERAL HOME, 202 GREENE ST., CUMBERLAND,

Item #5 Film #G437
6/1/71 pcs

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# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06492

06497

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| LOIS | M. | DETER | 5 13 71 | 8:35 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 12-23-25 / 12/23/25 | 45 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| DELAWARE | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLANDMD | MEMORIAL HOSPITAL | Cashier | Dept. Store |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 31 UTAH AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| ROBERT | W. | RICE | ADA | | SHOBE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 220-16-7179 | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Metastatic Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year

DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma Rectum — 3 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)

1541

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

None

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | Ca of rectum | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 5/10/71, 19__, to 5/13/71, 19__, that (I) (we) last saw the deceased alive on ____ 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE W. Royce Hodges, M.D. DEGREE: ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED 5/13/71

22d. PHYSICIAN'S NAME (Type) DR. R. HODGES

22e. ADDRESS CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 15, 1971 | Greenmount Cemetery | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli Cumberland Md. | MAY 21 1971 | Vernon A. Rudd |

VR A1 (14) 25m-1/70

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06493

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06498

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| LEROY | MERLE | DICKEN | 05 04 71 | 2:14PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | 04 24 30 | 41 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | DIVORCED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 903 HARDING AVE. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| MERLE | | DICKEN | (WINTERS) LEVINE | | DICKEN SEARS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| YES | 212 24 2366 | PATIENT'S HOSP. CHART 900 SETON DRIVE, CUMB. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 hr

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — 10 yr

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Emphysema Previous Myocardial Infarcts (3)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [X] NO [ ] | yes |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | | | | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| V. E. Mazzocco M.D. | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | | 5-7-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| V. E. MAZZOCCO, M.D. | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/7/71 | Sunset Memorial Park | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| STEIN'S FUNERAL HOME, 117 FREDERICK ST., CUMB., MD. | MAY 10 1971 | Vernon C. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15-(4)
25m-1170

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06494

# CERTIFICATE OF DEATH

06499

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Arthur | Middle: Raymond | Last: Diehl | 2a. DATE OF DEATH: Month May Day 18, Year 1971 at 5:00 A.M. | 2b. HOUR: 5 A.M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: 10/23/1893 | 6. AGE (In years last birthday): 77 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): Maryland | 7b. CITIZEN OF WHAT COUNTRY?: U.S. of America | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany County Md. | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Allegany County Infirmary | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Farm Worker | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Flintstone | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: Route #1 |
| 14. FATHER'S NAME First: Silas | Middle | Last: Diehl | 15. MOTHER'S MAIDEN NAME First: Luwinsey | Middle | Last: Barnes |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: Yes | (If yes give war or dates of service): WW 1 | 16b. SOCIAL SECURITY NO.: 705-10-6080 | 17. INFORMANT: A Allegany County Infirmary records. | Address: P.O. Box 599, Cumberland, Md. 21502 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cellulitis of left Leg. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: approx. 16 days
DUE TO, OR AS A CONSEQUENCE OF (b): Chr. A.S. Hyp. CVD — years
DUE TO, OR AS A CONSEQUENCE OF (c): Arterio-Sclerosis — many years
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chr. Brain Syndrome - Old C.V.A.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC. | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** that (I) (this hospital) attended the deceased from March 22, 1971, to May 18, 1971, that (I) (we) last saw the deceased alive on May 17, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John A Topper MD | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☒ STAFF PHYS. ☒ | 22c. DATE SIGNED: 5-18-71 | |
| 22d. PHYSICIAN'S NAME (Type): John A. Topper, M. D. | 22e. ADDRESS: Memorial Hospital, Cumberland, Md. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/21/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | 23d. LOCATION (City or Town): Nr. Cumberland | (County): Alleg (State): Md |
| 24. FUNERAL DIRECTOR: Hafer Funeral Service, | ADDRESS: 230 Balto Ave Cumberland Md | 25a. REC'D BY REGISTRAR DATE: MAY 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15 (4) 45M · 1 69

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

06495

06500

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: CATHERINE | Middle: ELIZABETH | Last: DOUTHITT | 2a. DATE OF DEATH Month: 05 Day: 30 Year: 71 | 2b. HOUR: 3:35 AM |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: JANUARY 11, 1914 | 6. AGE (In years last birthday): 57 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY COUNTY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): SECRETARY | 12b. KIND OF BUSINESS OR INDUSTRY: LAW OFFICE | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: BOX 323-E, WINCHESTER RD. | |
| 14. FATHER'S NAME First: JOHN | Middle: | Last: WEIMER | 15. MOTHER'S MAIDEN NAME First: ANNA | Middle: | Last: WILHELM |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: HOSPITAL RECORD, | Address: SACRED HEART HOSPITAL 900 SETON DRIVE, CUMB., MD. | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRO-VASCULAR ACCIDENT — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 MO
DUE TO, OR AS A CONSEQUENCE OF
(b): HYPERTENSIVE CARDIO-VASCULAR DISEASE — 6 YEARS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 7-5-65, 19__, to 5-30-71, 19__, that (I) (we) last saw the deceased alive on 5-29-71, 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Ralph W. Ballin M.D | DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 6-1-71 | |
| 22d. PHYSICIAN'S NAME (Type): R. W. BALLIN, M.D. | 22e. ADDRESS: 51 GREENE STREET, CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 6/2/71 | 23c. NAME OF CEMETERY OR CREMATORY: HILLCrest BURIAL PARK | 23d. LOCATION (City or Town) (County) (State): CUMBERLAND, ALLEGANY, MD. | |
| 24. FUNERAL DIRECTOR: H. WAYNE GEORGE | ADDRESS: GEORGE'S FUNERAL HOME, 202 GREENE STREET CUMBERLAND, MARYLAND | 25a. REC'D BY REGISTRAR: JUN 4 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

DHMH-16 1/71-30M
(VR A15 74)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06496 — 06501

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year |
| CHARLES | E. | ESHBAUGH | MAY 14, 1971 |

2b. HOUR: 2:35P M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 8-20-33 | 37 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Clerk | Shearing Co. |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES ☐ NO ☐ | 449 COLUMBIA ST., |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| ELMER | | ESHBAUGH | BERTIE | | WILT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| Yes | Korean | 300-30-5467 | Mrs. Elizabeth Eshbaugh, Cumberland, Md. Wife |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heartfailure

DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension.

DUE TO, OR AS A CONSEQUENCE OF (c)

401X

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 year. — —

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic renal disease.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH ☐ OR CONTRIBUTING ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from April, 1971, to 5/14, 1971, that (I) (we) last saw the deceased alive an 5/14 1971, and that in (my) (aur) apinian death accufred an the date and hour and from the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Peter B. Halmos | MD | ☑ | ☐ | ☐ | 5/16/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| PETER B. HALMOS, M.D. | MEMORIAL HOSPITAL, CUMBERLAND, MD |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| | May 17, 1971 | Restlawn Gardens | LaVale, Md. Allegany |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 21 1971 | Vernon G. Randall |

VR A15(4) 25m-1/70

3 1

06497

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06502

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: GOLDIE Middle: ELIZABETH Lost: FARRIS | 2a. DATE OF DEATH Month 5 Day 15 Year 71 | 2b. HOUR 5:45A | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-8-21 | 6. AGE (In years lost birthday) (50) 50 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): W.Va. | 7b. CITIZEN OF WHAT COUNTRY? usa USA | 8. MARRIED X NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES X NO ☐ 13e. STREET AND NUMBER: 315 S. CEDAR ST. |
| 14. FATHER'S NAME First Middle Lost: Earnest Henderson | 15. MOTHER'S MAIDEN NAME First Middle Lost: Grace Whisner | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD. | |

50 01 1

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] Pelvic Tumor Probably — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
235X
DUE TO, OR AS A CONSEQUENCE OF Women.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

X

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 4/26, 1971, to 5/15, 1971, that (I) (we) last saw the deceased alive on 5/15 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE [signature] DEGREE ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 5/17/71 | |
| 22d. PHYSICIAN'S NAME (Type) DR. B. SCHINDLER M.D. | 22e. ADDRESS CUMBERLAND, MD. | |

1

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 18,1971 | 23c. NAME OF CEMETERY OR CREMATORY: Great Capon Cemetery | 23d. LOCATION (City or Town) (County) (State): Great Capon,W.Va. |
| 24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. ADDRESS | 25a. REC'D BY REGISTRAR DATE MAY 21 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall | |

VR A15 (R) 25m-1/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

06498

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06503

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| DELILAH | M | FEICHTNER | MAY | 5 | 71 | 11:30 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | 7 2 1883 | 87 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNA | BEDFORD | HYNDMAN | YES ☐ NO ☒ | RD#1 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| JOSEPH | | EMERICK | ANN A | | Burns |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| No | | 170 38 1151 | | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart Failure
DUE TO, OR AS A CONSEQUENCE OF (b) Emphysema Arteriosclerotic Heart Disease
DUE TO, OR AS A CONSEQUENCE OF (c)

Conditians, if ony, which gave rise to immediote couse (a), stoting the underlying cause lost.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) unk (b) years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from May 16, 19 71, to May 5, 19 71, that (I) (we) last saw the deceased alive on May 5, 19 71, that to the best of my (our) opinion death occurred at the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] M.D. | | | | | 5/6/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. B. SCHINDLER PA. | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 8, 1971 | Palo Alto Cemetery | Hyndman RD#1 Bedford Co., Pa. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Harvey H. Zeigler, Hyndman, P. 15545 | MAY 14 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06499

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06504

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form ME-1.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| John | W. | Flora |

2a. DATE OF DEATH: KNOWN [X] ESTIMATED [ ] Month May Day 27 Year 1971 — 2b. HOUR 6a M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | Dec. 3, 1885 | 85 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month May Day 27, 1971 Year 19 — 2d. HOUR 6a M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | USA | MARRIED [ ] NEVER MARRIED [ ] WIDOWED [X] DIVORCED [ ] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Retired Mechanist | Railroad |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W.Va. | | Springfield | YES [ ] NO [X] | None |

| 14. FATHER'S NAME First Middle Last | 15. MOTHER'S MAIDEN NAME First Middle Last |
|---|---|
| George Flora | Emma Gurtler |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | Mr. William Z. Flora, Struthers, Ohio-Son |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Hemorrhage

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

4319

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

(a) ----

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [ ] NO [X] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote |
|---|---|---|
| | | |

22a. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X], Inquiry [X], and in my opinian death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED MAY 27, 1971

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 29, 1971 | Rose Hill Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JUN 1 1971 | Louise B. Randall |

VR A15ME (5) 10M - 1/69

06500

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13,ok,FilmG436 5/19/71 kam

# CERTIFICATE OF DEATH

06505

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Jennie | Virginia | Ford | May | 4 | 1971 | 10:5 P M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| Female | Black | May 27, 1905 | 65 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | U S A | WIDOWED [X] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Housewife | Self |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES / NO | 13e. STREET AND NUMBER (Correct) |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES [X] | John F. Kennedy Home |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | Harvey | | Mary | Elizabeth | Early |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 212-38-5513 | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcoma Uterus — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months,
1829
DUE TO, OR AS A CONSEQUENCE OF (b)
Canditions, if any, which gave rise to immediate couse (a), stating the underlying couse lost.
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Feb, 19 71, to My 5, 19 71, that (I) (we) last saw the deceased alive on _____ 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Blane M. Schindler M.D. | MD | [X] | ☐ | ☐ | 5/7/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Dr. Blane M. Schindler, M.D. P.A. | 43 Greene Street Cumberland, Maryland 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 5/ 8/1971 | Woodlawn Cemetery | Cumberland | Alleg | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Hafer Funeral Service | 230 Balto Ave. Cumberland | MAY 11 1971 | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

3 → 1

06501

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06506

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| WILLIAM | MC KINLEY | FOUTZ | 05 21 71 | 3:35 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 10-16-96 | 74 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED XX / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RAILROAD | RAILROAD |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES / NO X | ROUTE 1 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| NOBEL | | FOUTZ | (PRESTON) MATILDA | | FOUTZ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| NES | | 220-16-7047 | HOSPITAL REC., 900 SETON DR., CUMBERLAND, MD 21502 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Heart Failure - Post-Pneumonectomy -

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardiovascular Disease -

DUE TO, OR AS A CONSEQUENCE OF (c)

4/24 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Carcinoma of Rt. Lung -

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES / NO | |

| 21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, thot (I) (we) last sow the deceosed olive on 5/21 1971, and that in (my) (aur) opinian deoth occurred on the dote and haur and fram the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Calvin Y. Hadidian | ATTENDING PHYS. ✓ / MED. DIRECTOR / STAFF PHYS. | 5/21/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| C. HADIDIAN, M.D. | 203 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 5/24/71 | Laurel Hill Cemetery | Moscow | A. | Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| EICHHORN, 8 E. MAIN, LONACONING, MD. 21539 | MAY 25 1971 | Vernon P. Randall |

VR A15 (4) 25m-1/70

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06502

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06507

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copy sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) | First | Middle | Last |
|---|---|---|---|
| | SARAH | Anne GLAZE | (GLAZE) |

| 2o. DATE OF DEATH | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|
| | MAY | 30 | 71 | 2:50 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| female | WHITE | Sept. 27, 1886 | 84-84 YRS. | | |

| 7o. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12o. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | ALLEGANY CO INFIRMARY | HOUSEWIFE | Own Home |

| 13o. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | | 809 CECELIA STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | F. | MALONE | ANNABELLE | | CARTER |

| 16o. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 236-78-5188J1 | RECORDS ALLEGANY COUNTY INFIRMARY |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Cardiac Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hrs 50 min

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Chr. A.S. Hyp. C.V.D. — years

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chr. Brain Syndrome. Diabetes Mellitus.

| 19o. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20o. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21o. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22o. **I certify** that (I) (this hospital) attended the deceosed from MAY 25, 1969, to MAY 30, 1971, that (I) (we) last saw the deceased alive on May 30 1971, and that in (my) (aur) opinian death occurred on the date and haur and from the couses stated abave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John A Tepper MD | MD | ☒ | ☐ | ☐ | 5-31-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A Tepper MD. | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

| 23o. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | June 2, 1971 | Fort Ashby Cemetery | Fort Ashby, W. Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25o. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JUN 4 1971 | Vernon R. Randall |

VR A15 (4)
45M - 1/69

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06503

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06508

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| Elizabeth | Jane | Green | May | 4 | 1971 | 1.15 a M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | Jan. 6, 1897 | 74 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Frostburg | Miners Hospital | House wife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | MoscowMills | YES ☐ NO ☒ | R.D. 1 Barton, Md. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| George | Robertson | | Catherine | Symons | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| no | | Ellsworth Green-Lonaconing, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Cerebral Hemorrhage
DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditians, if any, which gave rise to immediate couse (a), stoting the underlying cause last.
4319

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
(a) 5-1-71
(b) years
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Nat while ot work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street ar R.F.D. No. | City ar Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 1969, to May 4, 1971, that (I) (we) last saw the deceased alive an May 3 1971, and that in (my) (our) apinion death accurred on the date and haur and from the couses stated abave. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Leslie R. Miles MD | | ☒ | ☐ | ☐ | 5-4-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Leslie R. Miles | Lonaconing, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/6/71 | Laurel Hill | Moscow Mills-Allegany-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. L. Boal | Westernport, Md. 21562 | MAY 6 1971 | Vernon G. Randall |

VR A15 (4)
45M - 4-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06504 06509

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HANNAH | ELLIOTT | GRINDLE | 05 08 71 | 7:55 P |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 11-08-95 | 75 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | WIDOWED [X] | ALLEGANY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | SACRED HEART HOSPITAL | | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [ ] NO [X] | RT 1, BOX 389 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | GEORGE | JOHNSON | TERNENT | JANE | A. JOHNSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | | HOSPITAL CHART, 900 SETON DR. CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIAC ARREST — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: MINS.
DUE TO, OR AS A CONSEQUENCE OF
(b) ACUTE MYOCARDIAL INFARCTION — MINS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c) ARTEMOSCLEROSES

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY Hour A.M./P.M. Month Day Year | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING CAUSE OF DEATH [ ] DR CONTRIBUTING [ ] | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 5-8, 1971, to 5-8, 1971, that (I) (we) last saw the deceased alive on 5-8 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| R. R. Espina, M.D. | M.D. | [X] | [ ] | [ ] | 5/10/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| R. R. ESPINA, M.D. | 924 SETON DR., CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/11/71 | Memorial Park | Frostburg A. Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| EICHHORN FUNERAL HOME, | 8 E. MAIN ST. LONACONING MARYLAND | MAY 11 1971 | Vernon R. Rudisill |

VR A15 (4)
25m- 1-70

1

06505

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06510

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| GERTRUDE | OWENS | HAMILTON | 5 28 71 | 11:05 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 01-26-~~02~~ 1910 | 61 ~~62~~ YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | USA | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MARYLAND | SACRED HEART HOSP. | CLERK-MAID | ~~HOUSEKAPT.~~ BUILDING |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 28 NORTH LEE STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | WADE | STALNAKER | ~~BRUBAKER~~ ANNA | MARY | Brubaker ~~STALNAKER~~ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|
| | 214-07-2219 | PATIENT'S HOSP. CHART | SACRED HEART HOSPITAL 900 SETON DR. CUMB., MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Carcinoma of Rectum — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 2.5 May 71 | Resection of Rectum | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) | UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 24 May 19 71, to 28 May 19 71, that (I) (we) last saw the deceased alive on 28 May 19 71, and that to (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (We) ~~did~~ did not view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Fred W. Miltenberger | | ☒ | ☐ | ☐ | 31 May 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. F.W. MILTENBERGER | 122 SO. CENTRE STREET CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | June 1, 1971 | Pine Glen Cemetery | McVeytown, Mifflin, Penna. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Philip B. Wendt WENDT FUNERAL HOME | CUMB., MARYLAND 121 MEMORIAL AVE. | JUN 2 1971 | Vernon O. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AT5 (4)
25m-1/70

1

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06506

06511

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print): First: Mildred; Middle: O.; Last: Hammond
2a. DATE OF DEATH: Month: 5; Day: 30; Year: 71
2b. HOUR: 4:15 PM
3. SEX: Female
4. RACE: White
5. DATE OF BIRTH: 10-26-01
6. AGE (In years last birthday): 69 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN.
7a. BIRTHPLACE (State or foreign country): Cumb. Md.
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Allegany Md.
10. CITY OR TOWN OF DEATH: Cumberland
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Cumb. Nursing Center
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housekeeper
12b. KIND OF BUSINESS OR INDUSTRY: at Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland
13b. COUNTY: Allegany
13c. CITY OR TOWN: Cumberland
13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 821 Yale Street
14. FATHER'S NAME: First: William; Middle: A.; Last: Brant
15. MOTHER'S MAIDEN NAME: First: Effie; Middle: ; Last: Wolford
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no
16b. SOCIAL SECURITY NO.: 214-07-0478 (If yes give wor or dates of service)
17. INFORMANT: Mr. Earl Hammond; Address: 821 Yale Str.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary artery disease. — yrs
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Cerebrovascular insufficiency.

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 4/8, 19 71, to 5/30, 19 71, that (I) (we) last saw the deceased alive on 5/28 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: PB Halmos — DEGREE: MD — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5/31/71
22d. PHYSICIAN'S NAME (Type): PB. HALMOS
22e. ADDRESS: 302 Sibley St, Cumberland.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6/2/71
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Maryland

24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. Cumberland, Md
ADDRESS: 21502
25a. RECD BY REGISTRAR DATE: JUN 4 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

VR A15 (2)
45M - 1 69

1

06507

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06512

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Nettie | Jane | Harrison | May | 5 | 1971 | 8:15 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| Female | White | April 10, 1882 | 89 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Md. | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during mast af warking life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Westernport | 320 Hammond | House wife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | | 320 Hammond |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Columbus | | Duckworth | Delilah | | Coleman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ar unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| no | | | Kenneth Harrison | Akron, Ohio |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Myocarditis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 Yrs
428X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b)
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| None | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature af injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | None |

| 21d. INJURY OCCURRED While at work ☐ Nat while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 10, 1971, to May 5, 1971, that (I) (we) last saw the deceased alive an May 4 1971, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Paul R. Wilson MD | | ☒ | ☐ | ☐ | May 6, 1971 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Paul R. Wilson | Piedmont, W.Va. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/8/71 | Philos | Westernport-Allegany-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. J. Boal | Westernport, Md. | MAY 10 1971 | Vernon G. Randall |

VR A15 (1)
45M - 1X69

1

06508

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06513 P

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| OPAL | E. | HASELBERGER | 5 17 71 | 12:45 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | 4-1-06 | 65 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.VA. | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | HOUSEWIFE | HOUSEWIFE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 511 PINE AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM, | | FANSLER | HULDA | | EYE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 220-10-4454 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Acute Myocardial infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Instant

DUE TO, OR AS A CONSEQUENCE OF

(b) Coronary atherosclerosis

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Pulmonary Emphysema

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William R Jeanes | | [ ] | [ ] | [ ] | 5/19/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. W. P. IAMES | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 20, 1971 | HILLCREST BURIAL PARK | CUMBERLAND ALLEGANY MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| SILCOX-MERRITT FUNERAL SERVICE | CUMBERLAND MD. | MAY 20 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

FOR STATE HEALTH DEPT.

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

06509

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06514

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: LAWRENCE | Middle: J. [redacted]R | Last: Helmstetter | 2a. DATE KNOWN OF DEATH ESTIMATED ☐ Month: MAY | Day: 8. | Year: 1971 | 2b. HOUR: 8 A.M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 1/26/89 | 6. AGE (In years last birthday): 82. YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD: Month: May 8. Day / Year: 1971 | 2d. HOUR: 9 A.M. |
| 7a. BIRTHPLACE (State or foreign country): CUMBERLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: [redacted] ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 412 Franklin St. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired Railroad Worker | 12b. KIND OF BUSINESS OR INDUSTRY: B&O | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 412 Franklin St. Cumberland Md. | | | |
| 14. FATHER'S NAME First: George E. | Middle | Last: Helmstetter | 15. MOTHER'S MAIDEN NAME First: Sebina | Middle: [redacted] | Last: Rahrig | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: Mrs. Pauline Stotler | ADDRESS: Cumberland, Md. | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

4109

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

IMMEDIATE CAUSE (a): Coronary Occlusion
DUE TO, OR AS A CONSEQUENCE OF
(b): Coronary Sclerosis
DUE TO, OR AS A CONSEQUENCE OF
(c):

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol couses ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
ADDRESS (Street, city, town, or county): Cumberland, Md.
22b. DATE SIGNED: May 8, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/11/71 | 23c. NAME OF CEMETERY OR CREMATORY: SS. Peter & Paul | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md. | |
| 24. FUNERAL DIRECTOR: Louis Stein, Inc. | ADDRESS: Cumberland Md. | 25a. REC'D BY REGISTRAR DATE: MAY 14 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15ME(5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06510

06515

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| MYRTLE | J. | HILL | 05 | 13 | 71 | 11:20 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | 05 22 06 | 64 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CRESAPTOWN | YES ☒ NO ☐ | FIR TREE LANE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOSEPH | FRANKLIN | BOOR | (illegible) ALAMO | Laura | BOOR Elliott |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 216 38 1536 | PATIENT'S HOSP. CHART | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

| PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardio renal vascular disease | 1 year |
| DUE TO, OR AS A CONSEQUENCE OF (b) | arteriosclerosis | 5 years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

404X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 4-6-71 | Gangrene left foot | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS DR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 3-12-, 1971, to 5-13, 1971, that (I) (we) last saw the deceased alive on 5-13- 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L Brings MD | | ☒ | ☐ | ☐ | 5-14-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. BRINGS, M.D. | 57 GREENE ST., CUMB., MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 5/15/1971 | Frostburg Memorial Park | Frostburg | Alleg | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Charles E. Hafer HAFER CHAPEL OF HILLS, LA VALE, MD. | | MAY 18 1971 | Vernon R. Randall |

VR A15 (4)
25m-1/70

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06511 — 06516

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the (funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1170

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EMMA | Middle: I. | Last: HOLSHEY | 2a. DATE OF DEATH Month: 5 | Day: 28 | Year: 71 |
| 2b. HOUR | 9:27 PM | | | | | |
| 3. SEX | FEMALE | 4. RACE | WHITE | 5. DATE OF BIRTH | 7-22-06 | 6. AGE (In years last birthday) | 64 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS.: HOURS / MIN | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒ | | 9. COUNTY OF DEATH | ALLEGANY COUNTY, Md. |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | MEMORIAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | MARYLAND | 13b. COUNTY | ALLEGANY | 13c. CITY OR TOWN | CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER | RT. #1 BX 438-B, |
| 14. FATHER'S NAME First | JOHN | Middle | MARKS | Last | 15. MOTHER'S MAIDEN NAME First | IDA | Middle | BURKHART | Last |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | No | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 214-05-8539 | 17. INFORMANT | MEMORIAL HOSPITAL | Address | CUMBERLANDMD. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Ca of breast ? wide metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 yrs

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying cause lost. 174X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from 5/25/71, 19___, to 5/28/71, 19___, that (I) (~~we~~) last saw the deceased alive on 5/28/71 19___, and that to (my) (~~best~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 6/1/71 |
| 22d. PHYSICIAN'S NAME (Type) DR. R.J.WILLIAMS | 22e. ADDRESS 122 S. CENTRE STREET CUMBERLAND MARYLAND | |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | June 1,1971 | Sunset Memorial Park | Cumberland, Allegany, Mdd. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JUN 3 1971 | Vernon R. Randall |

FOR STATE HEALTH DEPT.

06512

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06517

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. File Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN XX OF ESTIMATED ☐ Month Day Year | 2b. HOUR |
| MICHELLE | R. | HOWSARE | May 11, 1971 | 1:35p M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month Day Year | 2d. HOUR |
| Female | White | 12-23-66 | 4 YRS. | | | May 11, 1971 | 1:35p M |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH | |
| Maryland | USA | | Allegany | Md. |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
| Cumberland | Sacred Heart Hospital | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
| Maryland | Allegany | FROSTBURG | YES ☒ NO ☐ | 51 McCullough Street |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
| John W. | | Howsare | SHARON | | NEILSON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
| | NONE | JOHN W. HOWSARE, FROSTBURG, MD. 21532 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

8147

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Shock; Hemorrhage | 35 Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Ruptured Spleen; and Liver | 35 Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☒ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 1 P.M. 5-11-71 | Pedestrian struck by auto |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☒ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Street | 51 McCullough St. Frostburg, Alleg. Maryland |

22a. **I certify** that I took charge of the remains described above, held an Autopsy XX, Inspection XX, Inquiry XX, and in my opinion death resulted from: Natural causes ☐, Accident XX, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED May 11, 1971

ADDRESS (Street, city, town, or county)

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 14, 1971 | FBG. MEMORIAL PARK | FROSTBURG, MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DURST FUNERAL HOME, FROSTBURG, MARYLAND | MAY 17 1971 | Vernon B. Randall |

VR A15ME (5)
8M-1/70

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 M
45M - 1X69

06513

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06518

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: BESSIE | Middle: LEONA MORGAN | Last: JOHNSON | 2a. DATE OF DEATH: MAY Month 7 Day Year 71 |
| 2b. HOUR: 7:10P M | | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: OCTOBER 11, 1906 | 6. AGE (In years last Birthday): 64 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): ALLEGANY CO. INFIRMARY | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NURSES AIDE | 12b. KIND OF BUSINESS OR INDUSTRY: RETIRED |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutian: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: JOHN KENNEDY APT. 903 | | | |
| 14. FATHER'S NAME First: SCOTT | Middle: | Last: MORGAN | 15. MOTHER'S MAIDEN NAME First: Mary Middle: | Last: BARNES |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217-10-6294 | 17. INFORMANT Address: RECORDS ALLEGANY COUNTY INFIRMARY, BOX 590 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute Renal insufficiency | 7 days. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chr. C.V. Hypertensive C.V.D | years. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Metabolic Acidosis | 4 dys, appx. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0799

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Schizophrenia — Diabetes Mellitus

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | |
|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Dr John Topper | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 5-8-71 |
| 22d. PHYSICIAN'S NAME (Type): DR. JOHN TOPPER | 22e. ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/10/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | 23d. LOCATION (City or Town): Nr. Cumberland | (County): Alleg (State): Md |
| 24. FUNERAL DIRECTOR: Charles E. Hafer | ADDRESS: Hafer Funeral Service, 230 Balto Ave. Cumberland Md | 25a. REC'D BY REGISTRAR DATE: MAY 11 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

1

FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06514

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06519

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Henry | Middle: -- | Last: Jones | 2a. DATE KNOWN OF DEATH [X] ESTIMATED [ ] | Month: May | Day: 3, | Year: 19 71 |
| 2b. HOUR | 1:00 A.M. | | | | | | |
| 3. SEX | Male | 4. RACE | White | 5. DATE OF BIRTH | June 27, 1924 | 6. AGE (In years last birthday) | 46 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | | IF UNDER 24 HRS: HOURS / MIN. | | 2c. DATE PRONOUNCED DEAD | Month: May | Day: 3, | Year: 19 71 |
| 2d. HOUR | 1:00 A.M. | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | W. Va. | 7b. CITIZEN OF WHAT COUNTRY? | U. S. A. | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [X] | | 9. COUNTY OF DEATH | Allegany Md. |
| 10. CITY OR TOWN OF DEATH | Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | B. & O. Machinist | 12b. KIND OF BUSINESS OR INDUSTRY | Railroad |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | W. Va. | 13b. COUNTY | Mineral | 13c. CITY OR TOWN | Fort Ashby | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: Along Rt. # 46 nr. Fort Ashby, |
| 14. FATHER'S NAME | First: Henry | Middle: -- | Last: Jones | 15. MOTHER'S MAIDEN NAME | First: Letha | Middle: -- | Last: Roberts |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown) | Yes | (If yes give war or dates of service) | W.W. II | 16b. SOCIAL SECURITY NO. | 236-44-6936 | 17. INFORMANT | Mrs. Henrietta Sions ADDRESS Rt. # 1 Charles Town, W.Va. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Shock; Hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1½ Hrs.

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Ruptured heart & spleen — "

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [ ] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [X] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR ~~A.M.~~ 10:30 P.M. May 2, 19 71 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 ar Part 2, Item 18.) Auto accident - driver |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [X] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Rt. # 28, 1.4 mile South | 21f. LOCATION Street or R.F.D. No. Rt. # 9 nr. Fort Ashby City or Town Mineral County W. Va. State |

22a. **I certify** that I taak charge of the remains described abave, held an Autapsy [X], Inspection [X], Inquiry [X], and in my apinion death resulted from: Naturol causes [ ], Accident [X], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M. D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED May 3, 1971

ADDRESS(Street, city, town, or county) Cumberland, Maryland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/6/71 | Davis Cemetery | Antioch, Mineral, W.Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George Cumberland, Md. | MAY 10 1971 | Vernon B. Randall |

VR A15ME (5)
10M - 1/69

1

06515

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06520

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 haurs after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type ar print) | First: W. | Middle: PARKER | Last: JUDGE | 2a. DATE OF DEATH: Month MAY, Day 15, Year 71 | 2b. HOUR: 3:45 P.M. |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4 TO XX 1937 | 6. AGE (In years last birthday): 34 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State ar foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in haspital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind af wark dane during mast af warking life, even if retired.): GENERAL CONTRACTOR | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W. VA | 13b. COUNTY: MINERAL | 13c. CITY OR TOWN: KEYSER | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: RT 2 | |
| 14. FATHER'S NAME First: JOSEPH Middle: CHARLES Last: JUDGE | | 15. MOTHER'S MAIDEN NAME First: MARGUERITE Middle: | Last: MC COMAS | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, ar unknawn) (If yes give war or dates of service): NO | 16b. SOCIAL SECURITY NO.: 215 32 | 17. INFORMANT Address: 4898 MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter anly ane cause per line far (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Subendocardial Fiber Malacia | 5 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Coronary Sclerosis | 6 minutes |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Warfarin myocardial infarction | 2 wks |

4109 Conditians, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypercholesterolemia.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|

21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY OCCURRED (Enter nature af injury in Part 1 ar Part 2, Item 18.)

21d. INJURY OCCURRED While at wark [ ] Nat while at wark [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street ar R.F.D. Na. City ar Town County State

22a. I **certify** thot (I) (this haspitol) attended the deceased from 4-21, 19 71, to 5-15, 19 71, thot (I) (we) last saw the deceased alive on 5-15 19 71, and that in (my) (our) opinion deoth occurred an the date and hour ond from the couses stated above, (I) ~~(we)~~ (did) (~~did not~~) view the body after deoth.

22b. SIGNATURE: Vaughn P. Dross MD DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22c. DATE SIGNED: 5-16-71

22d. PHYSICIAN'S NAME (Type): DR. DROSS M.D.

22e. ADDRESS: CUMBERLAND, MD.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City ar Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 18, 1971 | PINTO MENNONITE CEMETERY | PINTO ALLEGANY MD |

24. FUNERAL DIRECTOR ADDRESS: SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD.

25a. REC'D BY REGISTRAR DATE: MAY 18 1971

25b. REGISTRAR'S SIGNATURE: Vernon B. Randall

VR A15 (4) 25m-1/70

1

06516

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06521

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| GARY | S | KAPLON | 5 5 71 | 12:15A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 1-11-51 | 20 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | NEVER MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Student | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 1404 HOLLAND ST. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| MARVIN | J. | KAPLON | HELEN | M. | MARX |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 214-46-3682 | MEMORIAL HOSPITAL CUMBERLAND, MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Respiratory Failure
DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMATOSIS
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1990
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|
| Robert D Brodell M.D. | ☑ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ROBERT BRODELL CMG | 500 GREENE ST. CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/6/71 | East View Cem. | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Lewis Stein Inc. | Cumb. Md | MAY 10 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06517 — 06522

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| LEOTA | MAE | KARNS | 5 | 20 | 71 | 12:05 A |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 05-23-03 | 67 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | SACRED HEART HOSP. | HOUSE WIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | PACA ST. (QUEEN CITY TOWERS) |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| THOMAS | | CONNOR | SMITH | JOSEPHINE | CONNER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | 17. INFORMANT Address |
|---|---|---|
| NO | 218-12-5703 | PT.'S HOSP. REC. 900 SETON DRIVE, CUMB., MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) ACUTE PULMONARY EDEMA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 HOUR

DUE TO, OR AS A CONSEQUENCE OF (b) ACUTE MYOCARDIAL INFARCTION - HRS

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 5/20, 19 71, to 5/22, 19 71, that (I) (we) last saw the deceased alive on 5/20 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| R C Smith | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 5/21/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R. R. ESPINA | 924 SETON DR. CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 22, 1971 | Sunset Memorial Park | Rd #3 Cumberland Allegany MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-FUNERAL HOME 404-DECATUR ST. CUMB., MD. MERRITT | MAY 24 1971 | Vernon O. Randall |

VR A15 (4)
25m-1/70

06817

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06518

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06523

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH / ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| John | Edward | Kelly | X / | May | 15, | 1971 | 11:33 |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year 19 | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | jan.28,1945 | 26 YRS. | | | | | May 15, | 1971 | 11 | :33a M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.Va. | U.S.A. | DIVORCED X | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sacred Heart Hospital | Student | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Westernport | YES X NO | 269 Main St. Ext. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | E. | Kelly | Lulu | | Rounds |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| yes | 1962-1963 | 213-44-1909 | John E. Kelly | Westernport, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Pulmonary Embolism, massive | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Paraplegia (venous stasis of | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Lower Extremities) (Automobile Accident) | 3 years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| April 19,1968 | Spinal Fusion | YES XX NO |

| 21a. EXTERNAL CAUSE WAS PRIMARY X OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| | March 1768 | Passenger in one car accident |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK X | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | Street | Cornwells Heights | | Bucks | Pa. |

22a. **I certify** that I took charge of the remains described above, held on Autopsy X, Inspection X, Inquiry X, and in my opinion death resulted from: Natural causes ☐, Accident X, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE EXAMINER'S NAME (Type) Benedict Skitarelic M.D. BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED May 15, 1971

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/18/71 | St. Peters | Westernport-Allegany-Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| E. L. Boal | Westernport, Md. | MAY 20 1971 | Vernon D. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**
**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DHR Page 5 may be retained for your files.
**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

1
FOR STATE HEALTH DEPT.

06519

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06524

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN / ESTIMATED OF DEATH | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Lula | -- | Kelso | ☒ KNOWN ☐ ESTIMATED | 5-31-71 | | 19 | 8:30p M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS: HOURS | MIN | 2c. DATE PRONOUNCED DEAD | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|
| Female | White | June 17, 1900 | 70 YRS. | | | | | Month May Day 31, Year 1971 | 8:30p M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | U. S. A. | MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, | Memorial Hospital | Domestic | Hotel, |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. Va. | Mineral | Ridgeley, | YES ☐ NO ☒ | Rt. # 1 Frankfort Rd. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Claude | -- | Wetzel | Elizabeth | -- | Camp |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| NO, | 234-58-1380 | Mrs. Robert L. Whitacre, | Rt. # 1 Ridgeley, W. Va. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CORONARY THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 Hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

DUE TO, OR AS A CONSEQUENCE OF (b) CORONARY SCLEROSIS — ----

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☒ NO ☐ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED: May 31, 1971

ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 6/3/71 | Frostburg Memorial Park | Frostburg, Allegany Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| H. Wayne George | 202 Greene St. Cumberland, Md. 21502 | JUN 4 1971 | Vernon R. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

7 1

06520

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06525

## CERTIFICATE OF DEATH

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Lost |
|---|---|---|
| IRENE | JOANA | KLOSTERMAN |

| 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|
| MAY | 30 | 71 | 7:50 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN |
|---|---|---|---|---|---|---|---|
| FEMALE | WHITE | AUG. 15, 1883 | 87 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| NEW YORK | U.S.A. | | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | ALLEGANY CO. INFIRMARY | HOUSEWIFE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☒ NO ☐ | 614 COLUMBIA ST. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Charles | | GOMEZ | Unknown. | | |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 214-32-3100-A | RECORDS ALLEGANY CO. INFIRMARY BOX 599 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute coronary thrombosis | 5 days. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chr. A.S.C.V.D. | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Generalized Arteriosclerosis | years. |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chr. Brain Syndrome.

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from FEB. 17, 1971, to MAY 30, 1971, that (I) (we) last saw the deceased alive on May 30 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John A Topper MD | | ☐ | ☐ | ☒ | 5 31 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A. Topper. MD | MEMORIAL HOSPITAL, CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 6/2/71 | St. Peter + Paul Cem | Cumberland Allegany MD |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Louis Stein Inc. | Cumb. MD. | JUN 3 1971 | Vernon B. Randall |

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06521 — 06526

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: CHARLES | Middle: L | Last: KOPP | 2a. DATE OF DEATH: 5 Month 25 Day 71 Year | 2b. HOUR: 4:15 M |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 5 5 87 | 6. AGE (In years last birthday): 84 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED * County School Supt. | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 927 BRADDOCK RD | |
| 14. FATHER'S NAME First: WILLIAM | Middle: L | Last: KOPP | 15. MOTHER'S MAIDEN NAME First: Elizabeth ~~MARGARET~~ | Middle: C. | Last: STOUGH |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown): Yes | (If yes give war or dates of service): WW I | 16b. SOCIAL SECURITY NO.: 214 42 0283 | 17. INFORMANT: MEMORIAL HOSPITAL, | Address: CUMBERLAND, MD. | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinomatosis, generalized — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 months

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Carcinoma ascending Colon — 21 month.

DUE TO, OR AS A CONSEQUENCE OF (c):

1530

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): H. & A.S. Cardiovascular disease.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: apx. 1969 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Carcinoma ascending Colon | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS DR CONTRIBUTING [ ] UNDERLYING CAUSE OF DEATH [ ] (If either, notify medicol examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this haspital) attended the deceased from Jan., 1967, to 25 May, 1971, that (I) ~~(we)~~ last saw the deceased alive an 25 May 1971, and that in (my) ~~(our)~~ apinian death accurred on the date and haur and fram the causes stated abave, (I) ~~(we) (did)~~ (did nat) view the bady after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE: W. Alfred Van Ormer, M.D. | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] | 22c. DATE SIGNED: 25 May 71 |
| 22d. PHYSICIAN'S NAME (Type): DR. W.A. VANORMER | | 22e. ADDRESS: CUMBERLAND, MD. | | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/28/71 | 23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park | 23d. LOCATION (City or Town): Cumberland | (County): Allegany (State): Maryland |
| 24. FUNERAL DIRECTOR: Silcox-Merritt Funeral Service. | ADDRESS: Cumberland, Md 21502 | 25a. REC'D BY REGISTRAR DATE: JUN 1 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | | |

VR A15 (4) 25m-1/70

1

06522

# MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

06527

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: LUELLA | Middle: CLARA | Last: LEASURE | 2a. DATE OF DEATH: 5 Month, 19 Doy, 71 Year | 2b. HOUR: 9:50 P.M. |
| 3. SEX: ~~FEMALE~~ FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 02-24-10 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): PENNSYLVANIA | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: MT. SAVAGE | 13d. INSIDE CITY LIMITS? YES [ ] NO [X] | 13e. STREET AND NUMBER: BOX 212 NEW ROW | |
| 14. FATHER'S NAME: First JOSEPH | Middle | Last FOX | 15. MOTHER'S MAIDEN NAME: First BRETH | Middle GERTRUDE | Last FOX |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 219-46-0372 | 17. INFORMANT: PT.'S HOSP. CHART | Address: 900 SETON DRIVE, CUMB. | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Complete heart block due to acute — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1/2 hour

DUE TO, OR AS A CONSEQUENCE OF (b): myocardial ~~infarction~~ ERROR SUBMISSION ISCHEMIA — 〃

DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerotic heart Disease — 〃

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Arteriosclerosis, General — Cerebral arteriosclerosis

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While [ ] at work Not while [ ] at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I **certify** that (I) (this hospital) attended the deceased from 1967, 19___, to 5/19, 1971, that (I) (we) last saw the deceased alive on 5/19, 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: S. G. Weisman MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 5/22/71 | | |
| 22d. PHYSICIAN'S NAME (Type): DR. S. G. WEISMAN | 22e. ADDRESS: 59 GREENE STREET CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/22/1971 | 23c. NAME OF CEMETERY OR CREMATORY: St. Patrick's Catholic Cem | 23d. LOCATION (City or Town): Mt. Savage, | (County): Alleg (State): Md. |
| 24. FUNERAL DIRECTOR: HAFER FUNERAL HOMES | ADDRESS: 58 FROST AVE. FROSTBURG | 25a. REC'D BY REGISTRAR DATE: MAY 26 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4) 25m-1/70

06822

1

FOR STATE HEALTH DEPT.

Items 20,22a Film 437 6/15/71 Item#6,Film#437 6/11/71 kam

# MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06523 06528

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: ~~Nancy~~ | Middle: Milson | Last: Leasure | 2a. DATE KNOWN OF DEATH ESTIMATED: [X] Month Day Year: May 31, 1971 | 2b. HOUR: 11a M | | |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Oct 7,1892 | 6. AGE (In years last birthday): 78 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month Day Year 19: May 31, 1971 | 2d. HOUR: 11a M | |
| 7a. BIRTHPLACE (State or foreign country): USA | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany Md. | | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Sacred Heart Hospital--DOA | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY: Const. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Frostburg | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 56 Frost Village | | |
| 14. FATHER'S NAME First: Daniel | Middle: T. | Last: Leasure | 15. MOTHER'S MAIDEN NAME First: Ruth | Middle: | Last: Piper | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217-07-0738-A | 17. INFORMANT: Nellie Leasure | ADDRESS: Frostburg, Md. 56 Frost Village | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN

DUE TO, OR AS A CONSEQUENCE OF

(b): CORONARY SCLEROSIS — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [X] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify thot I took charge of the remains described above, held on Autopsy [X], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: May 31, 1971

ADDRESS(Street, city, town, county): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 6-3-71 | Frostburg Mem. Park | Frostburg Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HAFER-SOWERS, FROSTBURG, MARYLAND | JUN 7 1971 | Vernon R. Randall |

VR A15ME (5) 10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06524 — 06529

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: MARY | Middle: FRANCES | Last: LECHLITER | 2a. DATE OF DEATH: 5 Month, 14 Day, 71 Year | 2b. HOUR: 12:0 A M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 05-29-14 | 6. AGE (In years last birthday): 56 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 745 MARYLAND AVE. | | |
| 14. FATHER'S NAME: First THEODORE | Middle | Last KASECAMP | 15. MOTHER'S MAIDEN NAME: First SWISHER | Middle VIRGINIA | Last KASECAMP | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk) NO | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: PATIENT'S HOSP. CHART | Address: ~~900 SETON DRIVE~~ CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Pulmonary Embolus, bilateral — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b): Phlebothrombosis

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1453X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Myocardial Infarction

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5/4, 19 71, to 5/13, 19 71, that (I) (we) last saw the deceased alive on 5/13 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: Leo L. Ley, Jr. MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | | | 22c. DATE SIGNED: 5/15/71 |
| 22d. PHYSICIAN'S NAME (Type): L. LEY | | 22e. ADDRESS: SACRED HEART HOSPITAL | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 17, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Lecliter Cemetery | 23d. LOCATION (City or Town): Short Gap | (County): Mineral W. Va. |
| 24. FUNERAL DIRECTOR: SCARPELLI FUNERAL HOME | ADDRESS: 108 VIRGINIA AVE. | 25a. REC'D BY REGISTRAR DATE: MAY 21 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15(4) 25m-1/70

1

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

06525

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06530

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
| HOWARD | | LEWIS | X | MAY | 15, | 1971 | 10 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month | Day | Year 19 | 2d. HOUR |
| Male | White | Oct. 29, 1894 | 76 YRS. | | | MAY | 15, | 1971 | 10 PM |

| | | | | |
|---|---|---|---|---|
| 7a. BIRTHPLACE (State or foreign country) W.Va. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH Allegany Md. | |
| 10. CITY OR TOWN OF DEATH Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Laborer | 12b. KIND OF BUSINESS OR INDUSTRY Textile Ind. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE W.Va. | 13b. COUNTY Mineral | 13c. CITY OR TOWN Short Gap | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER None |

| | | | |
|---|---|---|---|
| 14. FATHER'S NAME First / Middle / Last | 15. MOTHER'S MAIDEN NAME First / Middle / Last | | |
| David Lewis | Pownell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. 217-10-4068 | 17. INFORMANT ADDRESS Mrs. Naomi Lewis, Short Gap, W.Va. | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | SHOCK:; HEMORRHAGE | 2 Hours ; |
| DUE TO, OR AS A CONSEQUENCE OF (b) | RUPTURE OF ABDOMINAL ARTERIO- | @ 2 Hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) | SCLEROTIC ANEURYSM | |

4412

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☐ |

| | | | |
|---|---|---|---|
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Manth, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 ar Port 2, Item 18.) | |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At hame, form, street, factary, affice building, etc.) | 21f. LOCATION Street ar R.F.D. No. / City or Town / County / Stote | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspectian ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED May 15, 1971

ADDRESS(Street, city, town, or county)

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE May 19, 1971 | 23c. NAME OF CEMETERY OR CREMATORY Fort Ashby Cemetery | 23d. LOCATION (City or Town) (County) (State) Fort Ashby, W.Va. | |
| 24. FUNERAL DIRECTOR ADDRESS James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR DATE MAY 21 1971 | 25b. REGISTRAR'S SIGNATURE Vernon R. Randall | |

VR A15ME (5)
10M - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06526 06531

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: (JEANETTE M.) Middle: JEANNETTE M. Last: LIGHT | | | 2a. DATE OF DEATH Month: MAY Day: 3 Year: 1971 | 2b. HOUR: 9:30P |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 7-6-88 | 6. AGE (In years last birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: OWN HOME | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 511 PRINCE ~~GEORGE~~ GEORGE ST |
| 14. FATHER'S NAME First: ROBERT LEWIS Middle: Last: BARETT | | 15. MOTHER'S MAIDEN NAME First: VIRGINIA Middle: R Last: SULSER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 216 46 6002 | 17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD | | |

**MEDICAL CERTIFICATION**

1B. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) P PNEUMONIA — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5 DAYS

DUE TO, OR AS A CONSEQUENCE OF

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) CHRONIC REFRACTORY HEART FAILURE — MONTHS

DUE TO, OR AS A CONSEQUENCE OF

(c) GENERALIZED ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE — (YEARS)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 1956, 19__, to MAY, 197; , that (I) (We) last saw the deceased alive on MAY 3 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: MAY 6, 1971 | |
| 22d. PHYSICIAN'S NAME (Type): DR. G. O. HIMMELWRIGHT | 22e. ADDRESS: CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 6, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: MAY 10 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06527

Item#5,6,Film3437 6/9/71 kam

# CERTIFICATE OF DEATH

06532

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARGARET | E. | LINN | 05 22 71 | 11:30 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 12-21-93 1894 | 76 71 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. VA. | USA | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY CO. Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, MD. | MEMORIAL HOSPITAL | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | RT. 4 BOX 310 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | H. | RECKERT | SARAH | | HOUSE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | | Mr. Wm. G. Linn, Cumberland, Md. -Husband |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Cerebral Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 hrs.

DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4339

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS UNDERLYING / OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | Cumberland | Alleg. | Md. |

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from 4/7/68, 19____, to 7/22/71, 19____, that (I) (~~we~~) last saw the deceased alive on 7/22/71 19____, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE R. Williams M.D. — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED 5/22/71

22d. PHYSICIAN'S NAME (Type) DR. R. WILLIAMS — 22e. ADDRESS Cumberland, Md.

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 25,1971 | Mt. Tabor Cemetery | Near Oldtown, Md. Alleg. C. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 27 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A13(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06528

06533

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2o. DATE OF DEATH Month | Day | Year | 2b. HOUR |
| EDWIN | E. EATON | LUNDIEN | 05 | 25 | 71 | 5:06 M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS. HOURS | MIN. |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | 06 17 90 | 80 YRS. | | | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MINNESOTA | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | RETIRED B & O RAILROAD | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [ ] NO [ ] | RT. #2, CUMBERLAND, MD. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| AUGUST | OSCAR | LUNDIEN | ~~JOHNSON~~ ANNA | CHARLOTTE | CARLSON ~~LUNDIEN~~ |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| YES | WW 1 | 214-05-6809 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Squamous cell carcinoma (R) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

1450

Conditions, if any, which gave rise to immediate cause (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) bronchopneumonia, neurogenic.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] DR CONTRIBUTING [ ] CAUSE OF DEATH | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from May, 19 70, to 25 May 19 71, that (I) (we) last saw the deceased alive on 24 May 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Fred W. Miltenberger M.D. | ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 25 May 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| F.W. MILTENBERGER, M.D. | 122 S. CENTRE ST., CUMB., MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 5/27/1971 | Sunset Memorial Park | Nr. Cumberland | Alleg | Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| HAFER FUNERAL HOME, BALTIMORE AVE., CUMB., MD. | MAY 28 1971 | Vernon A. Randall |

VR AT 3-4
25m-1/70

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06529 06534

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| William | J. | Madigan | May 25 71 | 8:10 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 4-22-03 4-22-03 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Cumberland, Md. | America | | Allegany County Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, Md. | Lions Manor Nursing Home | R.R. Worker | Railroad |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | | 223 Arch St., |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| William H. | | Madigan | Mary | | Hardy |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address | |
|---|---|---|---|
| No | | Mr. Robert L. Madigan | Brother Cumberland, Md. |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Brain metastases | 1 & mos |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Lung- Carcinoma. | 2 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

1621

Conditions, if ony, which gave rise to immediate cause (a), stoting the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospital) attended the deceased from 19 June, 19 70, to _____, 19 ____, that (I) (we) lost saw the deceased alive an 25 May 19 71, and thot in (my) (our) opinion death accurred on the date and hour ond from the couses stated above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☐ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Dr. Earl [illegible] | | | | | 25 May 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| | Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 28, 1971 | St. Mary's Cemetery | Cumberland Alleg., Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | JUN 1 1971 | Thomas G. Randall |

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06530 06535

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| NANCY | L. | MAGUIRE | 5 5 71 | 9:45 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | 12-16-98 | 72 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MD. | USA | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Housewife | Own Home |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MD. | ALLEGANY | CUMBERLAND | YES X NO | 810 MD. AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| WILLIAM | H. | RHIND | ANNA | | CAMPBELL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| No | | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction, Pneumonia, Recent — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic heart disease
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last. 4100
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hypothyroidism — Pulmonary emphysema & fibrosis

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | NO | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I certify that (I) (this hospital) attended the deceased from 11/21, 1958, to 5/5, 1971, that (I) (we) last saw the deceased alive on 5/5 1971, and that in (my) (our) opinion death occurred on the dote and hour and from the causes stated abave. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Weisman MD | MD | X | | | 5/6/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. S. G. WEISMAN | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 7, 1971 | St. Mary's Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 11 1971 | Vernon R. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
25m-1/70

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06531 06536

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| BETTY | MAY | MAXEY | 05 26 71 | 12:10 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 04 16 26 | 45 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | TELEPHONE OPR. - C & P TELEPHONE | CO |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 20 SOUTH STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| BRUCE | E. | LICHTY | (BEECHLEY) HILDA | | Beachley XXXXX |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 212-24-2354 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | MD. 21502 |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) LEIOMYOSARCOMA, ABDOMINAL — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 MOS

1950

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b)

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| [ ] / [ ] | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10 - 4, 1969, to 5 - 26 MM 1971, that (I) (we) last saw the deceased alive on 5 - 25 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| R W Ballin M.D | | [X] | [ ] | [ ] | 5-26-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| R.W. BALLIN, M.D. | 51 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/29/71 | Beachdale Cemetery | Beachdale, Somerset, Penna. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Philip B. Wendt WENDT FUNERAL HOME, 121 MEMORIAL AVE., CUMB., MD. | JUN 1 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/89

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06532 06537

## CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year / 2b. HOUR |
| ANNA | ELEANOR | MILLER | MAY 20, 1971 / 2:50 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | AUG. 27, 1910 | 60 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| FROSTBURG | 79 SPRING STREET | HOUSEWIFE | OWN HOME |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | 79 SPRING STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| SIMEON | | CLARK | MARY | ETTA | ROSS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|---|
| NO | N.A. | NONE | FROSTBURG, MD. 21532 MR. ALBERT MILLER, 79 SPRING STREET, |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Coma Uremia | 1 hour |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Embolism Arteriosclerosis Hypertension | years |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Diabetes Mellitus | years |

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 2509

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I certify thot (I) (this hospitol) attended the deceased from January 1, 1922, to May 20, 1971, thot (I) (we) lost sow the deceased olive on May 20 19 71 and thot in(my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body ofter deoth.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Blane M. Schindler M.D. | M.D. | [X] | [ ] | [ ] | 5/21/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Blane M. Schindler, M.D. | 43 Greene St., Cumberland, Md. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 5/23/71 | FROSTBURG MEM. PARK | FROSTBURG, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR (Name) ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| MARLBOU M. SOWERS, HAFER-SOWERS FUNERAL HOME, 60 W. MAIN, FROSTBURG | MAY 26 1971 | Marlbou M. Sowers |

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06533

# CERTIFICATE OF DEATH

06538

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| COLLEEN | PATRICIA | MILLER | 05 10 71 | 1:05PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 04 21 56 | 15 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | NEVER MARRIED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | STUDENT | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| PENNSYLVANIA | Somerset | MEYERSDALE | YES [ ] NO [X] | RT. 4 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| PAUL | | MILLER | (SANNER) ARLENE | | MILLER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | | PATIENT'S HOSPITAL RECORD | 900 SETON DRIVE CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Adenocarcinoma cell sarcoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Yrs.
DUE TO, OR AS A CONSEQUENCE OF
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [X] | |

| 21a. ACCIDENT WAS / UNDERLYING CAUSE OF DEATH / CONTRIBUTING (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. **I certify** that (I) (this hospital) attended the deceased from Mar, 19 70, to 10 April 19 71, that (I) (we) last saw the deceased alive on 5/05 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Dr. Earl W. Campbell | | [X] | [ ] | [ ] | 10 May 71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| EARL W. CAMPBELL, MD | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/13/71 | St Mary's Cemetery | Cumberland All. Md |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| PRICE'S FUNERAL HOME, 325 MAIN ST., MEYERSDALE, PA. Mike Roy Lichtenberg | MAY 14 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-(70)

05634

Item 23, FilmG438 7/6/71 jep

Item #13, FilmG438 7/21/71 kam

FOR STATE HEALTH DEPT.

06534

# MARYLAND STATE DEPARTMENT OF HEALTH
# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06539

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Do not Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form DH2, Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5) 8M-1/70

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED [X] Month | Day | Year | 2b. HOUR |
| Lewis | Emory | Miller | May | 14 | 1971 | 7p M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month / Day / Year | 2d. HOUR |
| Male | White | 9/20/1914 | 56 YRS. | | | May 14 1971 | 11p M |
| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [xx] DIVORCED [ ] | 9. COUNTY OF DEATH | | | | |
| Penna. | U S A | | Allegany Md. | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| Flintstone | Rt.#1 Flintstone | Laborer | Celanese Corp | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institutional Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES [ ] NO [xx] | 13e. STREET AND NUMBER (Mailing address) | | | |
| Md. Pa. | Bedford Allegany | Flintstone | | Route 1, Flintstone, Md. | | | |
| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last | | |
| Richard | R | Miller | Melinda | Miller | Miller | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS | | | | | |
| No | 170-12-6407 | Virgil Miller, Route 1, Flintstone, Md. | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — --

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [X] |
|---|---|---|
| | | |

| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE Benedict Skitarelis M.D.

EXAMINER'S NAME (Type) BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED May 14, 1971

ADDRESS (Street, city, town, or county)

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/18/1971 | Prosperity Christian Cem | Near Flintstone Alleg Md |

24. FUNERAL DIRECTOR (Signature) Charles E. Hafer ADDRESS Hafer Funeral Service, 230 Balto Ave. Cumberland Md

25a. RECEIVED BY REGISTRAR MAY 19 1971

25b. REGISTRAR'S SIGNATURE Vernon C. Randall

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06535 — 06540

Item#6, Film#436 5/10/71 kam

## CERTIFICATE OF DEATH

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: SINCLAIR | Middle: | Last: MILLER | |
| 2a. DATE OF DEATH: MAY (Month) 2 (Day) 1971 (Year) | 2b. HOUR: 2:55P M | | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: NOV. 27, 1878 | 6. AGE (In years last birthday): 92 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN) |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): ALLEGANY CO. INFIRMARY | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MINER | 12b. KIND OF BUSINESS OR INDUSTRY: |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: BARTON | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: LATROBE STREET |
| 14. FATHER'S NAME First: CHARLES | Middle: O. | Last: MILLER | 15. MOTHER'S MAIDEN NAME First: CECELIA Middle: Last: NAUGHTON |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or Unknown): UNKNOWN (If yes give war or dates of service): NO | 16b. SOCIAL SECURITY NO.: 181-10-8081 | 17. INFORMANT: BOX 599 — Address: RECORDS ALLEGANY CO. INFIRMARY, CUMBERLAND, MD | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Acute occlusive Vascular disease — | approx. 5 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Chr. emphysema + Pulmonary fibrosis | approx. 6 yrs |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Senile Arteriosclerosis | many years |

492X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. **I certify** that (I) (this hospital) attended the deceased from Jan 20, 1969, to May 2, 1971, that (I) (we) last saw the deceased alive on May 2 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John A Topper M.D. | DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☒ | 22c. DATE SIGNED: 5 3 71 | |
| 22d. PHYSICIAN'S NAME (Type): DR. JOHN TOPPER | 22e. ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/5/71 | 23c. NAME OF CEMETERY OR CREMATORY: Laurel Hill | 23d. LOCATION (City or Town) (County) (State): Moscow Mills-Alle. Md. | |
| 24. FUNERAL DIRECTOR: E. L. Boal | ADDRESS: Westernport, Md. | 25a. REC'D BY REGISTRAR DATE: MAY 6 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

**TO HOSPITAL ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completed, filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (R) 45M 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06536 Item #14 & Item #1, Film G441 10/2 06541

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| (BABY) Emory | Francis | MINNICK, Jr. | 05 09 71 | 8:24 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years lost birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| MALE | WHITE | MAY 8, 1971 | YRS. | | XX / 50 |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | NEVER MARRIED XX | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART | NEW BORN | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | ECKHART | YES ☐ NO ☐ | P. O. BOX 144 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| EMORY | FRANCIS | MINNICK, Sr. | BARBARA | ANN | MILLER |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|---|
| NO | | | HOSPITAL RECORD, 900 SETON DRIVE, CUMBERLAND MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Respiratory Failure

DUE TO, OR AS A CONSEQUENCE OF (b) Hyaline membrane

DUE TO, OR AS A CONSEQUENCE OF (c) (? pneumothorax)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

7761

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☐ | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING ☐ CAUSE OF DEATH ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) |
|---|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Robert D. Brodell | | ☑ | ☐ | ☐ | |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| ROBERT D. BRODELL, M.D. | 500 GREENE STREET, CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 5-10-71 | ECKHART CEMETERY | ECKHART ALLE. MD |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| DURST FUNERAL HOME, 57 FROST AVENUE, FROSTBURG MD. 21532 | MAY 17 1971 | James B. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15(4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06537 06542

1

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| VIOLA | VIRGINIA | MINSHALL | 05 16 71 | 7:20 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 09 27 94 | 76 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| WEST VIRGINIA | U.S.A. | WIDOWED XX | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, | SACRED HEART HOSPITAL | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | WESTERNPORT | YES / NO X | ROUTE 1, BOX 7 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| DAVID | | EVANS | ARMEIDE | | KESSEL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT |
|---|---|---|
| NO | | CUMBERLAND, MD. 21502 HOSPITAL REC., SACRED HEART, 900 SETON DR., |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Left Femoral Nombolus

DUE TO, OR AS A CONSEQUENCE OF

(b) Arteriosclerotic Cardiovascular Disease

DUE TO, OR AS A CONSEQUENCE OF

(c)

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Diabetes Mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on 5-15 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| Calvin L. Hadidian | ATTENDING PHYS. X / MED. DIRECTOR / STAFF PHYS. | 5/17/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| CALVIN HADIDIAN, M.D. | 203 GREENE ST., CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/19/71 | Bloomington | Bloomington-Garrett-Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| BOAL'S FUNERAL HOME, 111 CHURCH ST., WESTERNPORT, MD. 21562 E. S. Boal | MAY 20 1971 | Vernon G. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (x)
25m-1/70

CUMBERLAND, MD. 21502

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06538 — 06543

1 FOR STATE HEALTH DEPT.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form VR A13.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) | First: Elizabeth | Middle: Jane | Last: Mooney | 2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ Month Day Year: May 25 1971 | 2b. HOUR: 1:50 M |
| 3. SEX: Female | 4. RACE: White | 5. DATE OF BIRTH: May 21, 1919 | 6. AGE (In years last birthday): 52 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD Month May Day 25 Year 1971 | 2d. HOUR: 1:50 M |
| 7a. BIRTHPLACE (State or foreign country): Penna. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. | | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): D.O.A. Sacred Heart Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Seamstress | 12b. KIND OF BUSINESS OR INDUSTRY: Mfg. Co. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md. | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER: Route 5, Fairgo | |
| 14. FATHER'S NAME First / Middle / Last: William Wilkie | | 15. MOTHER'S MAIDEN NAME First / Middle / Last: Mary Serfoss | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS: Mr. Joseph C. Mooney, Rt. 5, Cumberland | | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
DUE TO, OR AS A CONSEQUENCE OF
(b): CORONARY SCLEROSIS — -----
DUE TO, OR AS A CONSEQUENCE OF
(c):

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Noturol causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐ ASSISTANT MEDICAL EXAMINER ☐ DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county): Rt.9, Cumberland
22b. DATE SIGNED: May 26, 1971

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 27, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Sunset Memorial Park | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md. | |
| 24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md. | | 25a. REC'D BY REGISTRAR DATE: JUN 1 1971 | 25b. REGISTRAR'S SIGNATURE: Vincent R. Randall | |

VR A15ME (5) 10M - 1/69

Item 22a Film 437 6/15

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06539

06544

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or Print) First | Middle | Last |
|---|---|---|
| DONALD | Hayden | NEAVE |

2a. DATE KNOWN OF DEATH [XX] ESTIMATED [ ] Month 5 Day 2 Year 71 — 2b. HOUR 1:15 PM

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS HOURS | IF UNDER 24 HRS MIN. |
|---|---|---|---|---|---|---|---|
| Male | White | 09-08-35 | 35 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month May Day 2, Year 1971 — 2d. HOUR 2:00 PM

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Ohio | USA | DIVORCED [X] | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital--DOA | Weightmaster | Quarry |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Ohio | Prathesville | Painsville | YES [X] NO [ ] | 893 Richmond Road |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Theodore | | Neave | Dorothy | | Stone |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT ADDRESS |
|---|---|---|
| No | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

8122

IMMEDIATE CAUSE (a) SHOCK, HEMORRHAGE

DUE TO, OR AS A CONSEQUENCE OF

(b) RUPTURED AORTA: RUPTURED LEFT LUNG; RUPTURED LIVER; RUPTURED SPLEEN

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stoting the underlying couse last.

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) MINUTES; (b) ; (c) Sudden

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES [X] NO [ ] |

| 21a. EXTERNAL CAUSE WAS PRIMARY [XX] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Yeor HOUR A.M. P.M. | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | 1:15 PM 5-2-71 | Driver of Motorcycle involved in crash |

| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [XX] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. City or Town County State |
|---|---|---|
| | Rt. #220 | 500 ft. North Maryland Line, Bedford, Penns |

22a. **I certify** that I taak charge af the remains described above, held an Autapsy [X], Inspection [X], Inquiry [X], and in my apinian death resulted from: Natural causes [XX], Accident [X], Suicide [ ], Hamicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE EXAMINER'S NAME (Type): Benedict Skitarelic M.D. — BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [XX]
22b. DATE SIGNED: MAY 2, 1971
ADDRESS(Street, city, town, state): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/5/71 | Mentor Cemetery | Mentor Ohio |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. RECEIVED BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Philip B. Wendt 121 Memorial Ave., Cumb., Md. | MAY 3 1971 | Vernon G. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1 and 2 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06540 06545

# CERTIFICATE OF DEATH

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|
| Joseph | Ralph | Nestor | May | 24 | 1971 | 4:00 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| Male | White | Aug. 18, 1917 | 53 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va. | U. S. A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland, | Sacred Heart Hosp. | Foreman | B. & O. Rwy. |

| 13a. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☐ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| W. Va. | Mineral | Ridgeley | | Carpenter's Addition |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Hugh | Ernest | Nestor | Ada | -- | Plum |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| Yes, W. W. # 2 | 217-10-4154 | Mrs. Evelyn M. Maiers Carpenter's Add. | Ridgeley, W. Va. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Generalized metastase, — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

185X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Adeno-carcenima of Prostate.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| 1970 | Ca of Prostate | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from ____, 1969, to May, 1971, that (I) (we) last saw the deceased alive on May 10 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Valdes MD | | ☒ | ☐ | ☐ | 5-26-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| Jose L. Valdes, M. D. | Algonquin Hotel, Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/26/71 | Fort Ashby Cemetery | Fort Ashby Mineral W. Va. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | MAY 28 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06546

# CERTIFICATE OF DEATH

06541

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| OREN | ~~WALTER~~ William | O'NEAL | 05 / 26 / 71 | 12:43 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 11/06/06 | 64 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX / NEVER MARRIED ☐ / WIDOWED ☐ / DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNSYLVANIA | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Retired | Truck Driver |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES ☐ NO ☒ | RT.#3, BEDFORD RD., CUMB. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| HARTMAN | | O'NEAL | [redacted] HESTER | LAST | Williams |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| NO | 215-10-4432 | SACRED HEART HOSPITAL, 900 SETON DR., CUMB., MD. 21502 |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | Cardiac Arrest | |
| DUE TO, OR AS A CONSEQUENCE OF (b) | Acute Myocardial Infarction | 2 hrs. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | Coronary Artery Disease | unk. |

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☒ NO ☐ | Yes |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 10/15, 1969, to 5/26, 1971, that (I) (we) last saw the deceased alive on 5/26 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | 22c. DATE SIGNED |
|---|---|---|
| J.A. Pagan | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 5/27/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| J.A. PAGAN, M.D. | 1068 NATIONAL HWY., LA VALE, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/29/71 | Sunset Memorial Park | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-MERRITT FUNERAL HOME, DECATUR ST. CUMB., MD. 21502 | JUN 1 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item#13, Film#437 6/14/71 kam 06542

# CERTIFICATE OF DEATH

06547

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: Lois ~~MARY~~ Middle: Everett ~~XXXX~~ Last: OVERSTREET | 2a. DATE OF DEATH Month 5 Day 21 Year 71 | 2b. HOUR A 12:15 M | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 09-17-89 | 6. AGE (In years last birthday) 81 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN |
| 7a. BIRTHPLACE (State or foreign country): MISSISSIPPI | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, MD. | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSP. | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: ~~MARYLAND~~ Mississippi | 13b. COUNTY: ~~ALLEGANY~~ Jackson | 13c. CITY OR TOWN: ~~CUMBERLAND~~ Pascagoula | 13d. INSIDE CITY LIMITS? YES ☒ NO ~~XX~~ |
| 13e. STREET AND NUMBER: ~~BOX 1227~~ 1005 Colonial Manor | | | |
| 14. FATHER'S NAME First: Horace ~~MORRACE~~ Middle: B. Last: ~~EVERITT~~ Everett | 15. MOTHER'S MAIDEN NAME First: ~~XXXXXX~~ MARTHA Middle: Leticia Last: ~~EVERITT~~ Roberts | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, unknown) NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: PT.'S HOSP. REC. 900 SETON DR. CUMB., MD. | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) | ~~acute~~ Cardiac failure | 12 hours |
| DUE TO, OR AS A CONSEQUENCE OF (b) | acute septicemia | 12 hours |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

715X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Prosthesis inserted Right hip

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: 5-18-71 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: Arthritis R. hip | 20a. AUTOPSY? YES ☒ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this hospital) attended the deceased from 5-16-, 1971, to 5-20, 1971, that (I) (~~we~~) last saw the deceased alive on 5-20-1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | |
|---|---|---|
| 22b. SIGNATURE: Robert Feddis DEGREE | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED |
| 22d. PHYSICIAN'S NAME (Type): DR. ROBERT FEDDIS | 22e. ADDRESS: 500 GREENE ST. CUMBERLAND, MARYLAND | |

| | | | |
|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 24, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Mach Pelah Cemetery | 23d. LOCATION (City or Town) (County) (State): Pascagoula, Jackson, Miss. |
| 24. FUNERAL DIRECTOR: WENDT FUNERAL HOME Philip B. Wendt | ADDRESS: 121 MEMORIAL AVE. CUMB., MD. | 25a. REC'D BY REGISTRAR DATE: MAY 26 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon P. Randall |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06543 06548

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: LUCY | Middle: MARION | Last: PARKER | 2a. DATE OF DEATH: MAY Month 19 Day Year 71 — 2b. HOUR: 4:57 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: OCT. 23, 1898 | 6. AGE (In years last birthday): 72 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): ALLEGANY COUNTY INFIRMARY | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] — 13e. STREET AND NUMBER: 634 N. MECHANIC STREET |
| 14. FATHER'S NAME First: GEORGE | Middle: H. | Last: PENROD | 15. MOTHER'S MAIDEN NAME First: GERTRUDE | Middle: | Last: DEAN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown: NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: [redacted] 212-54-7118 | 17. INFORMANT: RECORDS | Address: ALLEGANY CO. INFIRMARY BOX 599 |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Carcinoma of cervix - pelvic metastasis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF (b): Chr. A.S.H.D. — years

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized arterio-sclerosis many years.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 180X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Old closed intertrochanteric fracture - L. hip.

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [X] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | |

22a. I certify that (I) (this haspitol) attended the deceased from DEC. 31, 1970, ta MAY 19, 1971, that (I) (we) lost saw the deceased alive an _____ 19____, and that in (my) (aur) apinion death occurred an the date ond haur and fram the couses stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: John A Topper MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] | 22c. DATE SIGNED: 5-21-71 | | |
| 22d. PHYSICIAN'S NAME (Type): DR. JOHN TOPPER | 22e. ADDRESS: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: MAY 22, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: SUNSET MEMORIAL PARK | 23d. LOCATION (City or Town) (County) (State): RFD# 3 CUMBERLAND ALLEGANY MD. | |
| 24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL SERVICE | ADDRESS: CUMBERLAND, MD. | 25a. REC'D BY REGISTRAR DATE: MAY 24 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

VR A15 (4) 45M - 1/69

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06544

# CERTIFICATE OF DEATH

06549

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: IDA Middle: F. Last: PEER | 2a. DATE OF DEATH Month 5 Day 31 Year 71 | 2b. HOUR 9:30AM | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 6-9-96 | 6. AGE (In years last birthday) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET AND NUMBER: 220 OAK ST. |
| 14. FATHER'S NAME First: JOHN Middle: Last: HOTT | | 15. MOTHER'S MAIDEN NAME First: JEMMA Middle: Jemima Hott Last: | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT: MEMORIAL HOSPITAL Address: CUMBERLAND, MD. | |

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01
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18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

180X

IMMEDIATE CAUSE (a) Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 18 hrs

DUE TO, OR AS A CONSEQUENCE OF

(b) Carcinoma Cervix Uterus

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

advanced bilat bronchiectasis, ASHD

MEDICAL CERTIFICATION

X

19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 1960, 19___, to 5-31, 1971, that (I) (we) last saw the deceased alive on 5-31 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: William H Jones, MD DEGREE ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 6/2/71

22d. PHYSICIAN'S NAME (Type): DR. W. P. IAMES | 22e. ADDRESS: CUMBERLAND, MD.

1

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: June 3,1971 | 23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.

24. FUNERAL DIRECTOR: James F. Scarpelli, Cumberland, Md. ADDRESS | 25a. REC'D BY REGISTRAR DATE JUN 9 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06545 06550

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: LAWRENCE; Middle: ; Last: PENNINGTON | 2a. DATE OF DEATH Month: 5; Day: 7; Year: 71 | 2b. HOUR 1:30P M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 7-25-03 | 6. AGE (In years last birthday): 67 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer | 12b. KIND OF BUSINESS OR INDUSTRY: B&O R.R. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: 807 MD. AVENUE |
| 14. FATHER'S NAME First: PHILLIP; Middle: ; Last: PENNINGTON | | 15. MOTHER'S MAIDEN NAME First: MARY; Middle: SUSAN; Last: FUNK | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service): A 705-05-8145 | 17. INFORMANT: MEMORIAL HOSPITAL | Address: CUMBERLAND, MD |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Tuberculosis 1st lung — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 0119

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from April 1, 1971, to May 7, 1971, that (I) (we) last saw the deceased alive on May 7 1971 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: B. Schindler M.D. — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 5/9/71

22d. PHYSICIAN'S NAME (Type): DR. B. SCHINDLER-PA — 22e. ADDRESS: CUMBERLAND, MD.

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: ~~April~~ May 10, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: Davis Memorial Cemetery | 23d. LOCATION (City or Town) (County) (State): Cumberland Allegany Md. | |
| 24. FUNERAL DIRECTOR: James F. Scarpelli | ADDRESS: 108 Va. Ave. Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: MAY 17 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon O. Randall | |

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06546 06551

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HARVEY | FREDERICK | PETERS | 05 03 71 | 7:30 A M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 04-04-03 | 68 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | U.S.A. | | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART HOSPITAL | Draftsman Engineer | Fibers |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | LA VALE | YES XX NO ☐ | 613 N. SECOND STREET |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JAMES | W. | PETERS | (FROST) ANNA | M. | PETERS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| No | 214-07-1747 A | Mrs. Edith Peters 612 N.2nd St. LaVale, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute myocardial infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 d
DUE TO, OR AS A CONSEQUENCE OF (b) Coronary sclerosis — unk
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stoting the underlying couse last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES ☐ NO ☒ | |

| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| V. E. Mazzocco | | ☐ | ☐ | ☐ | 5-4-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| V. E. MAZZOCCO, M.D. | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/6/71 | Sunset Memorial Park | Cumberland Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-MERRITT FUNERAL HOME, 404 DECATUR ST., CUMB., MD. 21502 | MAY 7 1971 | Homer D. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A (5-71) 25m-1/70

84630

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06547 06552

1. DECEASED-NAME (Type or print): First GEORGE Middle N Last PHILLIPPI
2a. DATE OF DEATH: Month MAY Day 26 Year 71
2b. HOUR: 7:55 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 8 18 87
6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): PA.
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED
12b. KIND OF BUSINESS OR INDUSTRY: Lumber Mill
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES [X] NO [ ]
13e. STREET AND NUMBER: 627 HILL TOP DR.
14. FATHER'S NAME First Uriah Middle M. Last PHILLIPPI
15. MOTHER'S MAIDEN NAME First REBECCA Middle Last Neff
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give wor or dates of service)
16b. SOCIAL SECURITY NO.: 214 05 5613
17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Myocardial Infarction — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hrs
4109
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES [ ] NO [ ]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) [ ]
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify thot (I) (this hospital) attended the deceased from 1-4, 1970, to 5-26, 1971, thot (I) (we) last saw the deceased alive an 5-26 1971, and thot in (my) (our) opinion deoth occurred on the date ond hour ond from the causes stoted above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wayne C Spigle MD — DEGREE: ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 5-28-71
22d. PHYSICIAN'S NAME (Type): BRADDOCK MEDICAL GROUP
22e. ADDRESS: SETON DR. CUMBERLAND MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 5/29/71
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (Stote): Cumberland Allegany Md.
24. FUNERAL DIRECTOR ADDRESS: Silcox-Merritt Fun. Ser. 404 Decatur St. Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 1 1971
25b. REGISTRAR'S SIGNATURE: Vernon G. Randall

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, both Parts 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 25m-1/70

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

# CERTIFICATE OF DEATH

06548 06553

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health and Mental Hygiene prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| MARION | BROWN | PLUMMER | 05 31 71 | 2:55 P.M. |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN |
|---|---|---|---|---|---|
| FEMALE | WHITE | APRIL 19, 1894 | 77 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | WIDOWED [X] | ALLEGANY COUNTY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | SACRED HEART | NONE | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FROSTBURG | YES [X] NO [ ] | ROUTE 1, BOX 253 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| CHARLES | S. | MC MILLAN | MELISSA | | MERRILL |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | XXX XX 6468 | HOSPITAL RECORD, | SACRED HEART HOSPITAL 900 SETON DR., CUMB., MD. |

## MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARCINAMATOSIS
DUE TO, OR AS A CONSEQUENCE OF (b) CA BREAST
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
174X
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 14 YRS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES [ ] NO [ ] | |

| 21a. ACCIDENT WAS / DR CONTRIBUTING / CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| UNDERLYING [ ] | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| [ ] / [ ] | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 4-27, 19 71, to 5-31, 19 71, that ~~(I)~~ (we) last saw the deceased alive on 5-31 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, ~~(I)~~ (we) (did) ~~(did not)~~ view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| L. Michael Glick | | [X] | [ ] | [ ] | 6-1-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| L. MICHAEL GLICK, M.D. | 912 SETON DRIVE, CUMBERLAND, MD. 21502 |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) | (County) | (State) |
|---|---|---|---|---|---|
| Burial | 6/3/71 | Memorial Park | Frostburg | A. | Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| EICHHORN FUNERAL HOME, | 8 E. MAIN STREET LONACONING, MD. 21539 | JUN 3 1971 | Vernon A. Randall |

DHMH-16 1/71 30M
(VR A15 (4))

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06549 06554

| 1. DECEASED-NAME (Type or print) First | Middle | Lost | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| HARRY | | RAINES | 5 15 71 | 6:15 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 11-15-06 | 64 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| W.VA. | USA | MARRIED X | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND, | MEMORIAL | RETIRED EMPLOYEE KELLY TIRE CO. | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | FLINTSTONE | YES / NO X | XXXXX RTE#1 ROUTE# 2 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| CHARLES | EDWARD | RAINES | CENA | XXXXX | THOMPSON |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| NO | | 214-05-9980 XXX-XX-XXXX | XXXXXXXXXXXXXXXX | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Refractory Left Ventricular failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Vascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4409

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 8 hrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | NO X | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medicol examiner) / UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** thot (I) (this hospitol) ottended the deceosed from April, 19 71, to 5-17, 19 71, thot (I) (we) lost sow the deceosed olive on 5-15 19 71, ond thot in (my) (our) opinion deoth occurred on the dote ond hour ond from the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

| 22b. SIGNATURE DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|
| William P. James MD | | X | | 5/16/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. WILLIAM P. IAMES | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 18, 1971 | SUNSET MEMORIAL PARK | RFD#3 CUMBERLAND ALLEGANY MD. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| SILCOX-MERRITT FUNERAL SERVICE CUMBERLAND MD. | MAY 18 1971 | Vernon O. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4) 25m 1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06550 — 06555

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: JOHN | Middle: ESBURY | Last: REDMOND | 2a. DATE OF DEATH Month 05 Day 27 Year 71 | 2b. HOUR 5:50 M |
| 3. SEX: MALE | 4. RACE: NEGRO | 5. DATE OF BIRTH: 09 22 97 | 6. AGE (In years last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): WEST VIRGINIA | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED XX NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY COUNTY, Md. | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): LABORER | 12b. KIND OF BUSINESS OR INDUSTRY: RAILROAD | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES XX NO ☐ | 13e. STREET AND NUMBER: 146 INDEPENDENT STREET | |
| 14. FATHER'S NAME First: GAITER | Middle: | Last: REDMOND | 15. MOTHER'S MAIDEN NAME First: BETTY | Middle: | Last: GREEN |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): YES | (If yes give war or dates of service): WW 2 | 16b. SOCIAL SECURITY NO.: 236 14 8220 | 17. INFORMANT: SACRED HEART HOSPITAL, 900 SETON DR., CUMB., | Address: MD. 21502 | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Massive CVA
DUE TO, OR AS A CONSEQUENCE OF (b): HASCVD
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4132
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a): Pneumonia - Possible

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. I certify that (I) (~~this hospital~~) attended the deceased from 5-24, 1971, to 5-27, 1971, that (I) (we) last saw the deceased alive on 5-26 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: M. L. Kaufman M.D. DEGREE | ATTENDING PHYS. ✓ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 5-27-71 | |
| 22d. PHYSICIAN'S NAME (Type): M. KAUFMAN, M.D. | 22e. ADDRESS: 924 SETON DR., CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: 5/29/71 | 23c. NAME OF CEMETERY OR CREMATORY: SUMNER CEMETERY | 23d. LOCATION (City or Town): CUMBERLAND | (County): (State): MD. |
| 24. FUNERAL DIRECTOR: KIGHT FUNERAL HOME, DECATUR ST., CUMB., MD. 21502 | ADDRESS | 25a. REC'D BY REGISTRAR DATE: JUN 1 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon B. Randall | |

VR A15 (4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06551 06556

1. DECEASED-NAME (Type or print): First BESSIE Middle M. Last REEL
2a. DATE OF DEATH: Month 5 Day 25 Year 71
2b. HOUR 5:25A M
3. SEX: FEMALE
4. RACE: WHITE
5. DATE OF BIRTH: 9-4-81
6. AGE (In years last birthday) 89 YRS. IF UNDER 1 YEAR: MONTHS DAYS; IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? USA
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
9. COUNTY OF DEATH: ALLEGANY Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife
12b. KIND OF BUSINESS OR INDUSTRY: Own Home
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: CUMBERLAND
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 516 PRINCE GEORGE ST.
14. FATHER'S NAME First FRANCIS T. Middle Last CORBETT
15. MOTHER'S MAIDEN NAME First JANE Middle Last BAXTER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service)
16b. SOCIAL SECURITY NO. 213-24-6385
17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic Ca Lungs and liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 yr.
DUE TO, OR AS A CONSEQUENCE OF
(b) Carcinoma of ovary — 4 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1830

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING CAUSE OF DEATH ☐ (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Not while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this haspitol) attended the deceased from 5-19, 1971, ta 5-25, 1971, that (I) (we) last sow the deceosed olive on 5-24 19 71, and thot in (my) (our) opinion deoth occurred on the dote ond hour ond fram the causes stated abave, (I) (we) ~~(did)~~ (did nat) view the bady after death.

22b. SIGNATURE: V. V. Nurse MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 5-25-71
22d. PHYSICIAN'S NAME (Type): V. V. Nurse MD
22e. ADDRESS: CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: May 28, 1971
23c. NAME OF CEMETERY OR CREMATORY: Hillcrest Burial Park
23d. LOCATION (City or Town) (County) (State): Cumberland, Allegany, Md.
24. FUNERAL DIRECTOR ADDRESS: James F. Scarpelli, Cumberland, Md.
25a. REC'D BY REGISTRAR DATE: JUN 1 1971
25b. REGISTRAR'S SIGNATURE: Vernon R. Randall

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06552

06557

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: Baby | Middle: Girl | Last: RITCHIE | 2a. DATE OF DEATH Month: 5 | Day: 21 | Year: 71 | 2b. HOUR: 2:07 P.M. |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 5-21-71 | 6. AGE (In years last birthday): 2HRS YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: FROSTBURG | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 212 W. MAIN ST. | | | |
| 14. FATHER'S NAME First: RANCE | Middle | Last: RITCHIE | 15. MOTHER'S MAIDEN NAME First: JUDITH | Middle: A | Last: MANKAMYER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL CUMBERLAND, MD. | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | RESPIRATORY FAILURE | 2 HOURS |
| DUE TO, OR AS A CONSEQUENCE OF (b) | HYPOPLASIA of the LUNGS | 2 HOURS |
| DUE TO, OR AS A CONSEQUENCE OF (c) | RENAL AGENESIS | 2 HOURS |

7486

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): PREMATURITY

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☑ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |
|---|---|---|---|

| 21a. ACCIDENT WAS (If either, notify medicol examiner) UNDERLYING ☐ DR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|

22a. **I certify** that (I) (this hospital) attended the deceased from 5-21 19 71, to 5-21, 19 71, that (I) (we) last saw the deceased alive on 5-21 19 71, and that in (my) (our) opinion death occurred an the date and haur and from the causes stated above, (I) (we) (did) (did nat) view the bady after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. ☑ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| Dan S. Fleming M.D. | | | | | 5-24-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. DAWSON-CMG | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | 5/22/71 | ST. PHILLIPS & JAMES CEMETERY | MEYERSDALE, PA. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| JOSEPH R. DURST, FROSTBURG, MD. 21532 | MAY 27 1971 | Vernon F. Randall |

VR A15 (4)
25m-1/70

FOR STATE HEALTH DEPT.

06553

MARYLAND STATE DEPARTMENT OF HEALTH
Item#1, Film G437 6/16/71 kam

06558

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Eldridge Middle: James Last: Saville | | | | | 2a. DATE KNOWN ☐ OF DEATH ESTIMATED ☐ Month: May Day: 31 Year: 1971 | | 2b. HOUR: 6: A M |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: April 3, 1917 | 6. AGE (In years last birthday): 54 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | 2c. DATE PRONOUNCED DEAD: Month May Day 31 Year 1971 | 2d. HOUR: 6: M |
| 7a. BIRTHPLACE (State or foreign country): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | | | 9. COUNTY OF DEATH: Allegany Md. | |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. Sacred Heart Hospital | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Carman | | 12b. KIND OF BUSINESS OR INDUSTRY: Railroad |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: W.Va. | 13b. COUNTY: Mineral | 13c. CITY OR TOWN: Ridgeley | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | | 13e. STREET AND NUMBER: Route 1 | | |
| 14. FATHER'S NAME First: Frederick Middle: Last: Saville | | | | | 15. MOTHER'S MAIDEN NAME First: Flossie Middle: Last: Mealis | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): War II Navy | | 16b. SOCIAL SECURITY NO.: 220-10-7766 | | | 17. INFORMANT: Mrs. Erma Saville, Ridgeley, W.Va. | ADDRESS: Wife | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchogenic Carcinoma — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 Year
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
1621
Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
|---|---|---|

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part I or Part 2, Item 18.) |
|---|---|---|
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined monner ☐

ACTUAL SIGNATURE: Benedict Skitarelis M.D.
EXAMINER'S NAME (Type): Dr. Benedict Skitarelic, M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
ADDRESS (Street, city, town, or county): Cumberland, Md.
22b. DATE SIGNED: May 31, 1971

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | June 3, 1971 | Sunset Memorial Park | Cumberland, Alleg., Md. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. RECD BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| James F. Scarpelli | Cumberland, Md. | JUN 3 1971 | Vernon A. Randall |

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06554 06559

1

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| CLARENCE | T | SEEDERS | 5 17 71 | 9:35PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 6-10-04 03 | 66 67 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | MARRIED X | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL | RETIRED | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| WEST VIRGINIA | | GREENSPRING | YES / NO X | |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| HENRY | C | SEEDERS | HANNAH | CATHERINE | WINDLE |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address |
|---|---|---|
| UNKNOWN | 232-10-5543 | MEMORIAL HOSPITAL CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchogenic Ca — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 months

DUE TO, OR AS A CONSEQUENCE OF (b) Ca Esophagus

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES / NO X | |

| 21a. ACCIDENT WAS (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH / DR CONTRIBUTING | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | Cumberland | Allegany | Md. |

22a. I certify that (I) (this hospital) attended the deceased from 4/15/71, 19____, to 5/17/71, 19____, that (I) (we) last saw the deceased alive on 5/17/71 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|
| [signature] | X | | | 5/19/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. R.J. WILLIAMS | 128 S. CENTRE STREET CUMB. MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/20/71 | Forest Glen Cemetery | Greenspring Hampshire W, Va. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| [signature] | Romney W. Va. | MAY 24 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06555 — 06560

1

1. DECEASED-NAME (Type or print): First CARSON; Middle J; Last SHAFFER
2a. DATE OF DEATH: Month 5; Day 13; Year 71
2b. HOUR: 10:00 PM
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: 12-31-80
6. AGE (In years last birthday): 90 YRS.
IF UNDER 1 YEAR: MONTHS; DAYS
IF UNDER 24 HRS.: HOURS; MIN
7a. BIRTHPLACE (State or foreign country): PENNA
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]
9. COUNTY OF DEATH: ALLEGANY COUNTY, Md.
10. CITY OR TOWN OF DEATH: CUMBERLAND,
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): MEMORIAL
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): RETIRED FARMER
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: ALLEGANY
13c. CITY OR TOWN: ELLERSLIE
13d. INSIDE CITY LIMITS? YES [ ] NO [ ]
13e. STREET AND NUMBER: P.O. BOX 197,
14. FATHER'S NAME First NATHAN; Middle; Last SHAFFER
15. MOTHER'S MAIDEN NAME First Lavinia; Middle; Last Conn
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 209-20-1877
17. INFORMANT: MEMORIAL HOSPITAL Address: CUMB. MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Ca of Pancreas
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse lost.
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES [ ] NO [X]
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 4/27/70, 19__, to 5/13/71, 19__, that (I) (~~we~~) last saw the deceased alive on 5/13/71 19__, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~we~~) (~~did~~) (did not) view the body after death.

22b. SIGNATURE AND DEGREE: [signature] M.D.
ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]
22c. DATE SIGNED: 5/15/71
22d. PHYSICIAN'S NAME (Type): DR. R.J. WILLIAMS
22e. ADDRESS: CENTRE STREET CUMBERLAND, MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: May 16, 1971
23c. NAME OF CEMETERY OR CREMATORY: Hyndman Cemetery
23d. LOCATION (City or Town) (County) (State): Hyndman, Bedford Co., Pa.
24. FUNERAL DIRECTOR ADDRESS: Harvey H. Zeigler, Hyndman, Pa. 15545
25a. RECEIVED BY REGISTRAR DATE: MAY 19 1971
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06556

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06561

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form VM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health priar to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost | 2a. DATE KNOWN OF DEATH ESTIMATED Month | Doy | Yeor | 2b. HOUR |
|---|---|---|---|---|---|---|
| Sara | E | Shank | X 5 | 7 | 1971 | 4 P.M |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | DAYS | IF UNDER 24 HRS HOURS | MIN. | 2c. DATE PRONOUNCED DEAD Month | Doy | Year | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Female | White | Aug 17, 1898 | 72 YRS | | | | | 5 | 7 | 1971 | 5P.M |

| 7a. BIRTHPLACE (Stote or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED WIDOWED DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Penna | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | DOA- Memorial Hospital | Housekeeper- At Home | |

| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES X NO | 110 Park Street |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Thomas | Goodwin | | Ida | Mae | Berg |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 173-18-3283 | Haud M. Shank | 110 Park Street Cumberland, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), ond (c).)

PART I. DEATH WAS CAUSED BY:

| Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| 4109 | IMMEDIATE CAUSE (o) Coronary Occlusion | Sudden |
| | DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis | -- |
| | DUE TO, OR AS A CONSEQUENCE OF (c) | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES NO X |

| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | Stote |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy, Inspection X, Inquiry X, ond in my opinian deoth resulted from: Natural causes X, Accident, Suicide, Homicide, Undetermined manner

ACTUAL SIGNATURE, EXAMINER'S NAME (Type): Benedict Skitarelic M.D. / Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER
ASSISTANT MEDICAL EXAMINER
DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED: May 7, 1971

ADDRESS(Street, city, town, State): CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/10/71 | Sunset Memorial Park | Cumberland Allegany Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md | 21502 | MAY 11 1971 | Vernon A. Randall |

VR A15ME (1)
10M - 1/69

1

06557

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06562

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| Frank | | Shuckhart | May 2 19 71 | 11 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS / DAYS | IF UNDER 24 HRS. HOURS / MIN. |
|---|---|---|---|---|---|
| Male | White | 01-16-93 | 78 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Sylvan Retreat | NONE | NONE |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Frostburg | | BORDEN MINES |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| John | | Shuckhart | Ellen | | Porter |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | 219-54-2149 | MRS. CHARLES LESSITER | BRADENTON, FLA. 5807 16th St. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute coronary occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: few minutes
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic — years
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis — years.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
Chronic Mental illness

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|

| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 6-27, 1967, to May 2, 1971, that (I) (we) last saw the deceased alive on May 2 1971, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| John A Tepper | MD | ☒ | ☐ | ☒ | 5-4-71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| John A. Tepper MD | Memorial Hospital, Cumberland, Md. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| BURIAL | MAY 5, 1971 | FROSTBURG MEM. PARK | FROSTBURG, ALLEGANY, MD. |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| MARILOU M. SOWERS, HAFER-SOWERS FUNERAL HOME | 60 W. MAIN, FROSTBURG | MAY 7 1971 | Vernon R. Randall |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06558

06563

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: MAE | Middle: A | Lost: SPANGLER | 2a. DATE OF DEATH Month: MAY Doy: 20 Yeor: 1971 |
| 2b. HOUR: P M 10:55 | | | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: I I4 85 | 6. AGE (In yeors lost birthday): Age 86 YRS. |
| IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | | |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street oddress): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): NONE Housewife | 12b. KIND OF BUSINESS OR INDUSTRY: Own Home |
| 13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ |
| 13e. STREET AND NUMBER: 410 BROADWAY | | | |
| 14. FATHER'S NAME First: HARRY | Middle: | Lost: NEWMAN | 15. MOTHER'S MAIDEN NAME First: ELLA Middle: Lost: COPP |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service): 220 48 7639 | 17. INFORMANT: MEMORIAL HOSPITAL, CUMBERLAND, MD. | Address |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one couse per line for (o), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (o): Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 D
Conditions, if ony, which gove rise to immediote couse (o), stoting the underlying couse lost. 4409
DUE TO, OR AS A CONSEQUENCE OF (b): Refractory Heart Failure — Wks
DUE TO, OR AS A CONSEQUENCE OF (c): Advanced Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☐ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) | |
| 21d. INJURY OCCURRED While ☐ at work Not while ☐ at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County Stote | |

22a. **I certify** that (I) (this haspital) attended the deceased from 5-17, 1971, to 5-20, 1971, that (I) (we) last saw the deceased alive an 5-20 1971, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: William A James, | DEGREE: MD | ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED: 8-22-71 |
| 22d. PHYSICIAN'S NAME (Type): DR. W. P. IAMES | IAMES | 22e. ADDRESS: CUMBERLAND, MD. | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: May 23,1971 | 23c. NAME OF CEMETERY OR CREMATORY: Terra Alta Cemetery | 23d. LOCATION (City or Town): Terra Alta, W.Va. | (County) (State) |
| 24. FUNERAL DIRECTOR: James T. Scarpelli | ADDRESS: Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: MAY 25 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | |

VR A15 (4)
25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06559 — 06564

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: EVELYN | Middle: NESBITT | Last: STICKLEY | 2a. DATE OF DEATH Month: MAY Day: 14, Year: 1971 | 2b. HOUR: 11:15 PM | |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 2-1-10 | 6. AGE (In years last birthday): 61 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife, Cook | 12b. KIND OF BUSINESS OR INDUSTRY: Hospital | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD. | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES [X] NO [ ] | 13e. STREET AND NUMBER: 301 OFFUTT STREET | | |
| 14. FATHER'S NAME First: GEORGE | Middle: W. | Last: DEAN | 15. MOTHER'S MAIDEN NAME First: HATTIE | Middle: V. | Last: BUCKLEY | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 213-24-7185 | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute left ventricular failure
DUE TO, OR AS A CONSEQUENCE OF (b): Acute myocardial infarction
DUE TO, OR AS A CONSEQUENCE OF (c): Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4/109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Diabetes mellitus

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES [ ] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that (I) (this hospital) attended the deceased from 5-11, 19 71, to 5-14, 19 71, that (I) (we) last saw the deceased alive on 5-14 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William P. James | | [X] | [ ] | [ ] | 5/16/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| William P. James M.D. ~~OVERTON TEMPLE WRIGHT MD~~ | 441 N. Centre St. ~~159 VIRGINIA AVE~~. CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/17/71 | Sunset Memorial Park, | Cumberland, Allegany Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| H. Wayne George 202 Greene St. Cumberland, Md. | MAY 19 1971 | Vernon R. Randall |

VR A15 (4) 25m-1/70

1

06560

# MARYLAND STATE DEPARTMENT OF HEALTH
## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
## CERTIFICATE OF DEATH

06565

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

| | | | | |
|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First: BERTHA | Middle: Ellen | Last: SUNDERLIN | 2a. DATE OF DEATH: 5 Month, 30 Day, 71 Yeor | 2b. HOUR: 6:30 M |
| 3. SEX: FEMALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 4-10-89 | 6. AGE (In years lost birthday): 82 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country): W.VA. | 7b. CITIZEN OF WHAT COUNTRY?: UNITED STATES | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): MEMORIAL HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: CUMBERLAND | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER: 815 OLDTOWN ROAD |
| 14. FATHER'S NAME First: JAMES | Middle: W. | Last: WARD | 15. MOTHER'S MAIDEN NAME First: MARY | Middle / Last: Derr ~~DURR~~ |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT Address: MEMORIAL HOSPITAL, CUMBERLAND, MD. | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Myocardial failure - left ventricular — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 hours

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): arteriosclerotic Heart Disease — 12 years

DUE TO, OR AS A CONSEQUENCE OF: (c): Chronic Hypertension with Heart Disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Ischemia CAD due to arteriosclerosis obliterans

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |

| | | | |
|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ UNDERLYING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. I certify thot (I) (this hospitol) attended the deceosed from _____, 19 57, to 5/30, 19 71, thot (I) (we) lost saw the deceosed olive on 5/30 19 71, and thot in (my) (our) opinion death occurred on the dote ond hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE: [signature] DEGREE | ATTENDING PHYS. ☒ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ |
| 22c. DATE SIGNED: 5/31/71 | | | |
| 22d. PHYSICIAN'S NAME (Type): DR.S.G.WEISMAN | 22e. ADDRESS: CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 6/2/71 | 23c. NAME OF CEMETERY OR CREMATORY: Green Spring Cemetery | 23d. LOCATION (City or Town) (County) (State): Green Spring, Mineral, W. Va. | |
| 24. FUNERAL DIRECTOR ADDRESS: Philip B. Wendt 121 Memorial Ave., Cumb., Md. | 25a. REC'D BY REGISTRAR DATE: JUN 7 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | | |

VR A15 (4)
25m-1/70

1
FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06561

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06566

| 1. DECEASED-NAME (Type or Print) First | Middle | Lost |
|---|---|---|
| PRALL | S. | TEMPERTON |

2a. DATE KNOWN OF DEATH ☐ ESTIMATED ☐ Month May Doy 2 Year 1971 — 2b. HOUR 9:10 M

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN |
|---|---|---|---|---|---|---|---|
| MALE | WHITE | June 19, 1901 | 69 YRS. | | | | |

2c. DATE PRONOUNCED DEAD Month May Doy 2 Year 1971 — 2d. HOUR 9:10 M

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| Penna. | USA | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | Memorial Hospital | Retired | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Md. | Allegany | Cumberland | YES ☒ NO ☐ | 2 Grand Ave. |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Jesse | | Temperton | Abbie | | Lee |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| No | | 078-01-0854 | Memorial Hospital | Cumberland, Md. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Days

4109

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ------

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Doy, Yeor HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, form, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I taak charge af the remains described abave, held an Autapsy ☐, Inspection ☒, Inquiry ☒, and in my apinian death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Dr. Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED May 3, 1971

ADDRESS(Street, city, town, or county) Rt. 9 Cumberland

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 5, 1971 | Allegany County Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 7 1971 | Vernon R. Randall |

VR A15ME (5) 10M - 1/69

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-[illegible]. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06562 — 06567

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month Day Year | 2b. HOUR |
|---|---|---|---|---|
| PAUL | LEE | THRASHER SR. | 5 17 71 | 9:05 PM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| MALE | WHITE | 11-7-92 | 78 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| MARYLAND | UNITED STATES | MARRIED X | ALLEGANY COUNTY, Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL | RETIRED | CARPENTER RAILROAD |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES X NO | 30 PENNSYLVANIA AVE. |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| BENJAMIN | | THRASHER | MARGARET | | WILLIAMS |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|---|
| UNKNOWN | | 705-05-1786 | MEMORIAL HOSPITAL | CUMBERLAND, MD. |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia

DUE TO, OR AS A CONSEQUENCE OF (b) Retroperitoneal Congestive Heart Failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. — DUE TO, OR AS A CONSEQUENCE OF (c) Advanced Arteriosclerosis

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Pulmonary Infarction - Chronic Obstructive Pulmonary Disease

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| | | YES / NO | |

| 21a. ACCIDENT WAS OR CONTRIBUTING (If either, notify medical examiner) | UNDERLYING CAUSE OF DEATH | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|---|
| | | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that (I) (this hospital) attended the deceased from 5-10, 19 71, to 5-17, 19 71, that (I) (we) last saw the deceased alive on 5-17 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| William P. Jenner | MD | | X | | 5/19/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. G.O. HIMMELWRIGHT | 133 VIRGINIA AVENUE CUMBERLAND, M |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 20, 1971 | Sunset Memorial Park | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| James F. Scarpelli, Cumberland, Md. | MAY 24 1971 | Vernon R. Randall |

VR A15 (M)
25m-1/70

1

**FOR STATE HEALTH DEPT.**

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)
1DM - 1/69

# MARYLAND STATE DEPARTMENT OF HEALTH

06563

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06568

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First | Middle | Lost | 2a. DATE KNOWN ☐ OF ESTIMATED ☒ DEATH Month | Day | Year | 2b. HOUR | | | | | |
| Ernie | | Turner | 5 | 17 | 1971 | 5:30 M | | | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS | IF UNDER 1 YEAR DAYS | IF UNDER 24 HRS. HOURS | IF UNDER 24 HRS. MIN | 2c. DATE PRONOUNCED DEAD Month | Day | Year | 2d. HOUR |
| Male | White | May 23, 1909 | 61 YRS. | | | | | 5 | 17 | 19 71 | 5:30 P M |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH |
|---|---|---|---|
| W. Va | U.S.A. | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| Cumberland | DOA - Memorial Hospital | Farmer- Lumberman | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Flintstone | YES ☐ NO ☒ | RFD #2 |

| 14. FATHER'S NAME First | Middle | Lost | 15. MOTHER'S MAIDEN NAME First | Middle | Lost |
|---|---|---|---|---|---|
| Isaac | | Turner | Gustava | | Ketterman |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|
| No | 217-18-4913 | Mrs. Vera Turner | RFD #2 Flintstone, Md |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
|---|---|---|
| IMMEDIATE CAUSE (a) | CORONARY OCCLUSION | SUDDEN |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109 — DUE TO, OR AS A CONSEQUENCE OF (b) | CORONARY SCLEROSIS | *--- |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES ☐ NO ☒ |

| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

22b. DATE SIGNED May 17, 1971

ADDRESS(Street, city, town, or county) CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | 5/20/71 | I.O.O.F. Cemetery | Flintstone Allegany Maryland |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| Silcox-Merritt Funeral Service. Cumberland, Md | 21502 | DATE MAY 20 1971 | Vernon R. Randall |

1
FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

06564

# MARYLAND STATE DEPARTMENT OF HEALTH

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06569

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Oscar | Middle: Henry | Last: Varner | 2a. DATE KNOWN OF DEATH ESTIMATED ☒: Month May Day 2, Year 1971 — 2b. HOUR 5:00 P.M. |
| 3. SEX: Male | 4. RACE: White | 5. DATE OF BIRTH: Oct. 3, 1904 | 6. AGE (In years last birthday): 66 YRS. — IF UNDER 1 YEAR: MONTHS, DAYS — IF UNDER 24 HRS.: HOURS, MIN. |
| | | | 2c. DATE PRONOUNCED DEAD Month May Day 2, Year 19 71 — 2d. HOUR 10:30 P.M. |
| 7a. BIRTHPLACE (State or foreign country): W. Va. | 7b. CITIZEN OF WHAT COUNTRY?: U. S. A. | 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: Allegany Md. |
| 10. CITY OR TOWN OF DEATH: Rt. # 5 Cumberland, | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Fairgo | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Ret. Warehouseman | 12b. KIND OF BUSINESS OR INDUSTRY: Celanese Fibre |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Cumberland, | 13d. INSIDE CITY LIMITS? YES ☐ NO ☒ — 13e. STREET AND NUMBER: Rt. # 5 Fairgo |
| 14. FATHER'S NAME First: David | Middle: -- | Last: Varner | 15. MOTHER'S MAIDEN NAME First: Delphia | Middle: -- | Last: Johnson |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No, (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 214-07-3755 | 17. INFORMANT: Mrs. Flossie M. Varner | ADDRESS: Rt. # 5 Cumberland, Md 21502 | | |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CORONARY OCCLUSION — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: SUDDEN
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
DUE TO, OR AS A CONSEQUENCE OF (b): CORONARY SCLEROSIS — ---
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES ☐ NO ☒ |
| 21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐ | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Benedict Skitarelic M.D.
EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M. D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX
22b. DATE SIGNED: May 2, 1971
ADDRESS (Street, city, town, or county): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/5/71 | 23c. NAME OF CEMETERY OR CREMATORY: Restlawn Memorial Gardens | 23d. LOCATION (City or Town): Cumberland, | (County): Allegany | (State): Md. |
| 24. FUNERAL DIRECTOR: H. Wayne George | ADDRESS: 202 Greene St. Cumberland, Md. | 25a. REC'D BY REGISTRAR DATE: MAY 10 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | | |

VR A15ME (5)
10M - 1/69

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

06565

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06570

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2 and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form HMS Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or Print) First: Bessie | Middle: E. | Last: Weekly | 2a. DATE OF DEATH KNOWN [X] ESTIMATED [ ] Month: May | Day: 6, | Year: 1971 | 2b. HOUR: 5:17 PM | |
| 3. SEX: F | 4. RACE: White | 5. DATE OF BIRTH: FEB. 28, 1899 | 6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN | 2c. DATE PRONOUNCED DEAD Month: May | Day: 6, | Year: 19 71 | 2d. HOUR: 5:17 PM |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: USA | 8. MARRIED [ ] NEVER MARRIED [ ] WIDOWED [XX] DIVORCED [ ] | 9. COUNTY OF DEATH: Allegany | | | | Md. |
| 10. CITY OR TOWN OF DEATH: Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Memorial Hospital | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY: HOUSEWIFE | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland | 13b. COUNTY: Allegany | 13c. CITY OR TOWN: Oldtown | 13d. INSIDE CITY LIMITS? YES [ ] NO [XX] | 13e. STREET AND NUMBER: R#1 BOX27 OLDTOWN MD. | | | |
| 14. FATHER'S NAME First: HOWARD | Middle: | Last: KIFER | 15. MOTHER'S MAIDEN NAME First: MARY | Middle: JANE | Last: STUMP | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 211-12-3328 | 17. INFORMANT ADDRESS: HAZEL KIFER RFD#1 BOX 27 OLDTOWN, MARYLAND | | | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Coronary Occlusion — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

DUE TO, OR AS A CONSEQUENCE OF

(b): Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | |
|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? YES [ ] NO [XX] |
| 21a. EXTERNAL CAUSE WAS PRIMARY [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
| 21d. INJURY OCCURRED WHILE AT WORK [ ] NOT WHILE AT WORK [ ] | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |

22a. **I certify** that I took charge of the remains described above, held on Autopsy [ ], Inspection [X], Inquiry [X], and in my opinion death resulted from: Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

ACTUAL SIGNATURE: Benedict Skitarelic M.D.

EXAMINER'S NAME (Type): BENEDICT SKITARELIC, M.D.

CHIEF MEDICAL EXAMINER [ ] ASSISTANT MEDICAL EXAMINER [ ] DEPUTY MEDICAL EXAMINER [X]

22b. DATE SIGNED: May 6, 1971

ADDRESS (Street, city, town, or): CUMBERLAND, MARYLAND

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL | 23b. DATE: MAY 10, 1971 | 23c. NAME OF CEMETERY OR CREMATORY: davis MEMORIAL PARK | 23d. LOCATION (City or Town): RFD#1 CUMBERLAND | (County): ALLEGANY (State): MD. |
| 24. FUNERAL DIRECTOR: SILCOX-MERRITT FUNERAL SERVICE | ADDRESS: CUMBERLAND MD. | 25a. REC'D BY REGISTRAR DATE: MAY 11 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon G. Randall | |

VR A15ME (5) 10M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

06566

# CERTIFICATE OF DEATH

06571

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Norman | Middle Ralph | Last Wertz |
| 2a. DATE OF DEATH Month Day Year | May 2 1971 | 2b. HOUR | 11:40 PM |
| 3. SEX | Male | 4. RACE | White |
| 5. DATE OF BIRTH | 5-12-06 | 6. AGE (In years last birthday) | 64 YRS. |
| IF UNDER 1 YEAR MONTHS / DAYS | | IF UNDER 24 HRS. HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | Pinto Md. | 7b. CITIZEN OF WHAT COUNTRY? | U.S.A. |
| 8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ | | 9. COUNTY OF DEATH | Allegany Md. |
| 10. CITY OR TOWN OF DEATH | Cumberland | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | Cumb. Nursing Center |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Plumber | 12b. KIND OF BUSINESS OR INDUSTRY | Self-Employed |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | Maryland | 13b. COUNTY | Allegany |
| 13c. CITY OR TOWN | Cumberland | 13d. INSIDE CITY LIMITS? YES ☐ NO ☑ | |
| 13e. STREET AND NUMBER | Rt. 1 Valley Road | | |
| 14. FATHER'S NAME First / Middle / Last | Charles Wertz | 15. MOTHER'S MAIDEN NAME First / Middle / Last | Elizabeth Schultz |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service) | No | 16b. SOCIAL SECURITY NO. | 217-10-7870 |
| 17. INFORMANT | Mrs Patricia Wertz | Address | 305 Industrial Blvd. Cumb. Maryland |

**MEDICAL CERTIFICATION**

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cancer of Sigmoid colon — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 mo
DUE TO, OR AS A CONSEQUENCE OF (b) & metastases to liver
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1533

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES ☐ NO ☑ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
| 21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State | |

22a. **I certify** that (I) (this hospital) attended the deceased from February, 19 70, to 2 May, 19 71, that (I) (we) last saw the deceased alive on 3/1 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| | | | |
|---|---|---|---|
| 22b. SIGNATURE | Andrew Stasko MD | DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ | 22c. DATE SIGNED 5-3-71 |
| 22d. PHYSICIAN'S NAME (Type) | Andrew Stasko, M. D. | 22e. ADDRESS | 401 Decatur St., Cumberland, Md. 21502 |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) | |
| Burial | 5/5/71 | Restlawn Memorial Gardens | LaVale, Allegany, Md. | |
| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE | |
| H. Wayne George | Cumberland, Md. | MAY 10 1971 | Vernon R. Randall | |

VR A 15 M
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06567 — 06572

1

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in, file with the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | Middle | Last | 2a. DATE OF DEATH Month / Day / Year |
| NORA | Ellen | WHARTON | 5 / 11 / 71 |

2b. HOUR: 10:25 A.M.

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
|---|---|---|---|---|---|
| FEMALE | WHITE | 7X-4-85 | 85 YRS. | | |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| PENNA. | USA | WIDOWED [X] | ALLEGANY Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| CUMBERLAND | MEMORIAL HOSPITAL | Housewife | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| MARYLAND | ALLEGANY | CUMBERLAND | YES [X] NO [ ] | 106 LAING AVENUE |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| JOHN | Thomas | RICE | Mary Elizabeth | | BRANT |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | Address |
|---|---|---|---|
| NO | | MEMORIAL HOSPITAL | CUMBERLAND, MD |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) C V A

DUE TO, OR AS A CONSEQUENCE OF (b) Congestive Heart Failure

DUE TO, OR AS A CONSEQUENCE OF (c) Urinary Bladder Infection

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: months / week / months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES / NO | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? |
|---|---|---|---|
| X | | | |

| 21a. ACCIDENT WAS OR CONTRIBUTING / UNDERLYING CAUSE OF DEATH (If either, notify medical examiner) | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED While at work / Not while at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. / City or Town / County / State |
|---|---|---|
| | | |

22a. I **certify** that (I) (this hospital) attended the deceased from May 1, 19 71, to 5/11, 19 71, that (I) (we) last saw the deceased alive on 5/11, 19 71, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

| 22b. SIGNATURE | DEGREE | ATTENDING PHYS. | MED. DIRECTOR | STAFF PHYS. | 22c. DATE SIGNED |
|---|---|---|---|---|---|
| [signature] | MD | [X] | [ ] | [ ] | 5/12/71 |

| 22d. PHYSICIAN'S NAME (Type) | 22e. ADDRESS |
|---|---|
| DR. B. SCHINDLER-PA | CUMBERLAND, MD. |

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Town) (County) (State) |
|---|---|---|---|
| Burial | May 14, 1971 | Restlawn Cemetery | Cumberland, Allegany, Md. |

| 24. FUNERAL DIRECTOR ADDRESS | 25a. REC'D BY REGISTRAR DATE | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|
| Philip B. Wendt 121 Memorial Ave., Cumb., Md. | MAY 17 1971 | Vernon R. Rundell |

VR A15(3) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06568 — 06573

1

| | | | | | | |
|---|---|---|---|---|---|---|
| 1. DECEASED-NAME (Type or print) | First: THOMAS | Middle: NMI | Last: WHITEHEAD | 2a. DATE OF DEATH: Month 05 Day 13 Year 71 | 2b. HOUR: 1:10 M | |
| 3. SEX: MALE | 4. RACE: WHITE | 5. DATE OF BIRTH: 02 27 98 | 6. AGE (In years last birthday): 73 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. | |
| 7a. BIRTHPLACE (State or foreign country): MARYLAND | 7b. CITIZEN OF WHAT COUNTRY?: U.S.A. | 8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐ | 9. COUNTY OF DEATH: ALLEGANY Md. | | | |
| 10. CITY OR TOWN OF DEATH: CUMBERLAND | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): SACRED HEART HOSPITAL | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): MINING | 12b. KIND OF BUSINESS OR INDUSTRY: COAL MINING | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND | 13b. COUNTY: ALLEGANY | 13c. CITY OR TOWN: MIDLOTHIAN | 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First: WILLIAM | Middle | Last: WHITEHEAD | 15. MOTHER'S MAIDEN NAME First: (EISENTROUT) AMANDA | Middle | Last: WHITEHEAD | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO.: 217 07 2174 | 17. INFORMANT: PATIENT'S HOSP. CHART | Address: 900 SETON DRIVE CUMBERLAND, MD. | | | |

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): PNEUMONITIS - TERMINAL
1419
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): METASTASES TO LUNGS
DUE TO, OR AS A CONSEQUENCE OF (c): CARCINOMA TONGUE, TONSIL, ORO PHARYNX
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION: SAN 171 | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED: CARCINOMA - TONGUE | 20a. AUTOPSY? YES ☐ NO ☒ | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES |

| | | | | |
|---|---|---|---|---|
| 21a. ACCIDENT WAS OR CONTRIBUTING ☐ (If either, notify medical examiner) UNDERLYING CAUSE OF DEATH ☐ | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED While at work ☐ Not while at work ☐ | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County / State |

22a. I **certify** that (I) (this hospital) attended the deceased from SAN. , 1971 , to MAY 13 , 1971 , that (I) (we) last saw the deceased alive an APRIL 10 1971 , and that in (my) (~~our~~) apinian death accurred an the date and haur and fram the causes stated abave, (I) (~~we~~) (did) (did nat) view the bady after death.

| | | | | |
|---|---|---|---|---|
| 22b. SIGNATURE: Arthur S. Bauer M.D. | DEGREE | ATTENDING PHYS. ☑ | MED. DIRECTOR ☐ | STAFF PHYS. ☐ |
| 22c. DATE SIGNED: 5-14-71 | | | | |
| 22d. PHYSICIAN'S NAME (Type): ARTHUR S. BAUER, M.D. | | 22e. ADDRESS: ALGONQUIN HOTEL, CUMB., MD. 21502 | | |

| | | | | | |
|---|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify): Burial | 23b. DATE: 5/16/1971 | 23c. NAME OF CEMETERY OR CREMATORY: Frostburg Memorial Park | 23d. LOCATION (City or Town): Frostburg | (County): Alleg | (State): Md. |
| 24. FUNERAL DIRECTOR: HAFER'S FROST MANSION, | ADDRESS: FROSTBURG, MD. 21532 | 25a. REC'D BY REGISTRAR DATE: MAY 18 1971 | 25b. REGISTRAR'S SIGNATURE: Vernon R. Randall | | |

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25m-1/70

08369

OBS-23

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

06569 — 06574

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers — pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | |
|---|---|---|---|
| 1. DECEASED-NAME (Type or print) First | NANCY | Middle W | Last YEW |
| 2a. DATE OF DEATH Month | 5 | Day 4 | Year 71 |
| 2b. HOUR | 3:15 PM | | |
| 3. SEX | FEMALE | | |
| 4. RACE | WHITE | | |
| 5. DATE OF BIRTH | 10-31-94 | | |
| 6. AGE (In years last birthday) | 78 YRS. | IF UNDER 1 YEAR: MONTHS / DAYS | IF UNDER 24 HRS.: HOURS / MIN. |
| 7a. BIRTHPLACE (State or foreign country) | MARYLAND | | |
| 7b. CITIZEN OF WHAT COUNTRY? | UNITED STATES | | |
| 8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ] | | | |
| 9. COUNTY OF DEATH | ALLEGANY Md. | | |
| 10. CITY OR TOWN OF DEATH | CUMBERLAND | | |
| 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | MEMORIAL HOSPITAL | | |
| 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | Owner | | |
| 12b. KIND OF BUSINESS OR INDUSTRY | Resturant | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | MARYLAND | | |
| 13b. COUNTY | ALLEGANY | | |
| 13c. CITY OR TOWN | CUMBERLAND | | |
| 13d. INSIDE CITY LIMITS? | YES [X] NO [ ] | | |
| 13e. STREET AND NUMBER | 515 MARSHALL STREET | | |
| 14. FATHER'S NAME First | ALBERT | Middle | Last WHETSELL |
| 15. MOTHER'S MAIDEN NAME First | MINNIE | Middle | Last Elliott |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) | No | | |
| 16b. SOCIAL SECURITY NO. | 213-22-3555 | | |
| 17. INFORMANT Address | MEMORIAL HOSPITAL, CUMBERLAND, MD. | | |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of Lung
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4560
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 3 months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | |
|---|---|---|---|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | |
| 20a. AUTOPSY? | YES [X] NO [ ] | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | Yes |
| 21a. ACCIDENT WAS OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner) | UNDERLYING [ ] | 21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19 | |
| 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED While at work [ ] Not while at work [ ] | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | |
| 21f. LOCATION Street or R.F.D. No. | | City or Town Cumberland | County Allegany |
| State Md. | | | |

22a. I certify that (I) (this hospital) attended the deceased from 4/26/71, 19____, to 5/4/71, 19____ that (I) (we) last saw the deceased alive on 5/3/71 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

| | | | | | |
|---|---|---|---|---|---|
| 22b. SIGNATURE | R. J. Williams M.D. | DEGREE | ATTENDING PHYS. [X] | MED. DIRECTOR [ ] | STAFF PHYS. [ ] |
| 22c. DATE SIGNED | 5/4/71 | | | | |
| 22d. PHYSICIAN'S NAME (Type) | DR. R.J. WILLIAMS | 22e. ADDRESS | CUMBERLAND, MD. 21502 | | |

| | | | | |
|---|---|---|---|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | Burial | 23b. DATE | 5/6/71 | |
| 23c. NAME OF CEMETERY OR CREMATORY | Hillcrest Burial Park | 23d. LOCATION (City or Town) (County) (State) | Cumberland Allegany Md. | |
| 24. FUNERAL DIRECTOR | Byron Kight | ADDRESS | Cumberland, Md. | |
| 25a. REC'D BY REGISTRAR DATE | MAY 10 1971 | 25b. REGISTRAR'S SIGNATURE | Vernon G. Randall | |

VR A (5-4) 25m-1/70

MARYLAND STATE DEPARTMENT OF HEALTH

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

06570

06575

FOR STATE HEALTH DEPT.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, Md. 21201
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 16. Give Pages 1 and 2 with the State Department of Health and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME (Type or Print) First | Middle | Last | 2a. DATE KNOWN OF DEATH ESTIMATED | Month | Day | Year | 2b. HOUR |
|---|---|---|---|---|---|---|---|
| Walter | William | Yoder | X | May | 6, | 1971 | 7 AM |

| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR: MONTHS | DAYS | IF UNDER 24 HRS.: HOURS | MIN | 2c. DATE PRONOUNCED DEAD: Month | Day | Year 19 | 2d. HOUR |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Male | White | 2/23/1923 | 48 YRS. | | | | | May | 7, | 1971 | 2 PM |

| 7a. BIRTHPLACE (State or foreign country) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED X NEVER MARRIED WIDOWED DIVORCED | 9. COUNTY OF DEATH |
|---|---|---|---|
| Maryland | U S A | | Allegany Md. |

| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | 12b. KIND OF BUSINESS OR INDUSTRY |
|---|---|---|---|
| ~~Winchester Rd. Route~~ R D Cumberland | Winchester Road Route 5 | Vice Pres. Walter Yoder & Sons Inc | |

| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | 13e. STREET AND NUMBER |
|---|---|---|---|---|
| Maryland | Allegany | Cumberland | YES NO X | Winchester Rd. Route 5 |

| 14. FATHER'S NAME First | Middle | Last | 15. MOTHER'S MAIDEN NAME First | Middle | Last |
|---|---|---|---|---|---|
| Walter | N. | Yoder | Pearl | | Porter |

| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | (If yes give war or dates of service) | 16b. SOCIAL SECURITY NO. | 17. INFORMANT | ADDRESS |
|---|---|---|---|---|
| Yes | WW 2 | 220-16-6066 | Phyllis Yoder, | P O Box 1337, Cumberland Md |

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis, left — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden

4100

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Coronary Sclerosis — ---

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Hypertensive cardiovascular disease (Cardiac Hypertrophy)

| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | 20. AUTOPSY? |
|---|---|---|
| | | YES X NO |

| 21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH | 21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19 | 21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Port 2, Item 18.) |
|---|---|---|
| | | |

| 21d. INJURY OCCURRED WHILE AT WORK / NOT WHILE AT WORK | 21e. PLACE OF INJURY (At hame, farm, street, factary, office building, etc.) | 21f. LOCATION Street or R.F.D. No. | City or Town | County | State |
|---|---|---|---|---|---|
| | | | | | |

22a. I certify that I taak charge af the remains described abave, held an Autapsy X, Inspection X, Inquiry X, and in my apinian death resulted from: Natural causes X, Accident ☐, Suicide ☐, Hamicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Benedict Skitarelic M.D.

EXAMINER'S NAME (Type) Benedict Skitarelic, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER XX

22b. DATE SIGNED May 7, 1971

ADDRESS (Street, city, tawn, CUMBERLAND, MARYLAND

| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE | 23c. NAME OF CEMETERY OR CREMATORY | 23d. LOCATION (City or Tawn) (County) (State) |
|---|---|---|---|
| Burial | 5/ 9/1971 | Sunset Memorial Park | Nr. Cumberland, Alleg Md |

| 24. FUNERAL DIRECTOR | ADDRESS | 25a. REC'D BY REGISTRAR | 25b. REGISTRAR'S SIGNATURE |
|---|---|---|---|
| John F. Hafer | Hafer Funeral Service, 230 Balto Ave. Cumberland Md | MAY 11 1971 | Vernon G. Randall |

VR A15ME (5) 8M-1/70